BEHAVIORAL HEALTH SERVICES REFERRAL FORM

DATE OF REFERRAL_____

NAME OF CLIENT: _____ DATE OF BIRTH: _____

CLIENT'S ADDRESS:
_____
_____
_____
_____
_____

INSURANCE CARRIER:
_____
MEMBER NAME:
_____
MEMBER ID:
_____

CLIENT'S PHONE:
_____

REFFERING PROGRAM/AGENCY: _____

REFERRING CASE WORKER(S) NAME & CONTACT INFORMATION:

NAME:
_____
ROLE:
_____
PHONE:
_____
EMAIL:
_____

NAME:
_____
ROLE:
_____
PHONE:
_____
EMAIL:
_____

REASON FOR REFERRAL: (THERAPY AND/OR PSYCH MEDICATION MANAGEMENT - LIST MAIN CONCERNS TO BE ADDRESSED)

_____
_____
_____
_____

- **RELEASE OF INFORMATION FORM NEEDS TO BE SIGNED AND SENT WITH THIS FORM. IF CLIENT IS HOMELESS AND STAYING AT THE SHELTER, PLEASE HAVE CLIENT SIGN RELEASE FOR THE SHELTER TOO.**
- **ALL REFERRALS CAN BE FAXED TO 920-437-9480 OR EMAILED TO: BHInbox@newcommunityclinic.org**