



REFERRAL TO BEHAVIORAL HEALTH SERVICES

SECTION I

Date: _____ MID _____

Patient's name: _____ DOB: _____ Phone: () _____

County: _____

Payer Source: ___ Medicaid ___ Medicare ___ Health Choice ___ Private ___ Self Pay

Legal Guardian: _____ Phone: () _____

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment.

Referring Primary Care Provider's Name: _____

Address:

Phone: () _____ Fax: () _____ Email: _____

Referral Request

Specific concerns and requests:

The following patient information is attached.

- Medical Diagnosis(es)
- Most Recent History and Physical
- Current Medication List
- Recent Labwork
- Pain Contract (if applicable)
- Other _____

Signature: _____

(Physician/Physician Assistant/Nurse Practitioner)

Thank you for agreeing to evaluate this patient.

***** Please fax Section II to the Primary Care Provider listed above. *****