PASSIONATE
Behavioral Health Center, Inc.

Passionate Behavioral Health Center Referral Form

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Thank you for your referral, our agency will be contacting you to confirm that the referral was received. Please also discuss the intent of this referral with you client. We will be Contact the client to schedule an appointment.

Referral Date: ________________ Referral Phone#: ______________________ Referral Fax#: __________________

Referral Source (Name and/or Agency): ____

Referral Address: ____

Client Name: ____________________________ DOB: ___________________ Gender: _______________________

Ethnicity: ____________________________ SS#:_________________________ Medicaid#:_____________________

Residing with (name/relationship): ____

Address: ____

Contact Home Phone: _____________________________ Contact alternate phone:_________________________

Other important contact information (e.g. biological family): ____

Other Important Phone Numbers: ____

Presenting Concerns /Comments (attach additional sheet if needed):

____
____
____
____

Diagnosis (if known): ____

Referral Services requested for (check all that apply):

- ☐ ***Individual therapy***
- ☐ ***Family therapy***
- ☐ ***Group therapy***
- ☐ ***Intensive Outpatient***
- ☐ ***Partial hospitalization***
- ☐ ***Psychiatric Rehab Program (PRP)***
- ☐ ***Medication Assisted Treatment***
- ☐ ***Medication Management***
- ☐ ***DUI***
- ☐ ***Early Intervention***

Location of Services Requested

- ☐ ***In Home***
- ☐ ***In Office***
- ☐ ***Either location***
- ☐ ***Other location: ____***

Type of Insurance

- ☐ ***Medicaid or Medical Assistance***
- ☐ ***Medicare***
- ☐ ***Private Insurance (type): __________________________________***

Policy #: ________________________ Group#: _____________________ Phone#:_____________________

We strive to provide compassionate and highest quality healthcare to our clients and their families through mental health services