

Request for Behavior Health Services

Staff completing form:			Date:
Referral Source:			Release: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:		DOB:	
Address:		Phone:	
Referral Questions	YES	NO	Comments
Ok to leave message on phone?	<input type="checkbox"/>	<input type="checkbox"/>	
Health insurance? What type?	<input type="checkbox"/>	<input type="checkbox"/>	
Presenting Issue:			
Plan for follow-up (contact within two weeks):			