Behavioral Health Patient Referral Form

Referral Date

Month Day Year

Referral

Referring Source

Please Select

Referring Hospital/Clinic/Agency/Location

Referring Provider

Point of Contact/Case Manager

Point of Contact Phone Number

Please enter a valid phone number.

Point of Contact Email

example@example.com

Is the patient being referred for court ordered (CCOP) mental health treatment?

- ○ Yes
- ○ No

If yes, please provide details.

Patient Details

Name

First Name Last Name

Date of Birth

Month Day Year

Patient Address

Address

City

Post Code

Cell Phone Number (patient or guardian)

Please enter a valid phone number.

Work Phone Number

Please enter a valid phone number.

Email

Relevant Medical History

Reason for Referral

Behavioral Health Services Requested

- ○ Counseling
- ○ Medication Management
- ○ Both

Reason for Referring Patient

- ☐ Anxiety
- ☐ Depression
- ☐ Grief
- ☐ Poor self-care due to mental health
- ☐ Psychosis (auditory/visual hallucinations, delusional)
- ☐ PTSD/Trauma
- ☐ Violence/Aggressive Behavior
- ☐ Difficult/Unable to go to work/school
- ☐ Perinatal Depression and/or Anxiety
- ☐ Chronic Pain
- ☐ Other

Other Information