MENTAL HEALTH REFERRAL FORM

REFERRAL SOURCE					
AGENCY		PHONE			
LOCATION		EMAIL			
FORM COMPLETED BY		PHONE		DATE	

RECEIVING AGENCY			
AGENCY		PHONE	
LOCATION		EMAIL	

CLIENT INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		GENDER	
SOCIAL SECURITY #		MEDICAID #	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
GUARDIAN NAME		GUARDIAN RELATIONSHIP	
CLIENT'S ADDRESS		CELL PHONE	
		HOME PHONE	
		WORK PHONE	
		EMAIL	

PRESENTING CONCERNS / COMMENTS Attach additional sheets and / or supporting documentation as deemed necessary.	
REASON FOR REFERRAL	
PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.	
SERVICE / SPECIALTY REQUESTED	
ADDITIONAL COMMENTS	

INSURANCE INFORMATION												
AUTHORIZATION REQUIRED?		YES		NO	AUTH #		# OF VISITS		AUTH EXP. DATE			
	PPO		HMO		OTHER	INSURANCE PLAN						
INSURANCE ID			MEDICAL GROUP				PHONE #					
INSURANCE HOLDER'S NAME				RELATIONSHIP TO PATIENT			DOB					

RECEIVING AGENCY | DOCUMENTATION OF RECEIPT			
METHOD OF DELIVERY		DATE RECEIVED	

DISCLAIMER

Any articles, templates, or information provided by Smartsheet on the website are for reference only. While we strive to keep the information up to date and correct, we make no representations or warranties of any kind, express or implied, about the completeness, accuracy, reliability, suitability, or availability with respect to the website or the information, articles, templates, or related graphics contained on the website. Any reliance you place on such information is therefore strictly at your own risk.