

PM Form 3.3.1
ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES

I. Information on Person Making Referral

Today's Date and Time _____

Name and Title _____

Affiliated Agency _____ Phone _____ Fax _____

Relationship with Person Being Referred _____

II. Information on Person Being Referred for Services

Name _____ Date of Birth _____ Age _____ Gender F M

Address _____

City _____ State _____ Zip _____ Phone _____

Parent/Legal Guardian (if applicable) _____ Phone _____

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (include phone) _____

Person/Parent/Guardian is aware of referral: No Yes

Cultural and language considerations No Yes, specify language/need _____

Special Needs:

Mobility Assistance No Yes, identify assistance needed _____

Visual Impairment Assistance No Yes, identify assistance needed _____

Hearing Impairment Assistance No Yes, identify assistance needed _____

Developmental or Cognitive Impairment No Yes, identify assistance needed _____

Payment Source: AHCCCS ID # _____ Private insurance _____ Medicare
 Self pay Health Plan _____

PCP _____ Phone _____ Fax _____

Check any of the following which pertain to the person being referred:

Shows evidence of suicidal or homicidal thoughts or behaviors Identified need for psychotropic medications

Pregnant Woman Is currently hospitalized Was recently discharged from an inpatient setting

Has immediate medical needs Other potential risk factors, e.g., dehydrated, malnourished, homeless

Reason for Referral, including an explanation of any items checked above _____

Additional information and contact information _____

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? Yes No, if no, when will she/he exhaust the current supply of medications _____

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III. Information to Be Completed by T/RBHA/Provider

Date / Time Received _____

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care: _____

Type of Appointment Immediate Urgent Routine

Available Intake Appointment Offered, specify date, time, place _____

Action Taken

Scheduled Intake Appointment, specify date, time, place _____

Not Referred for Appointment, specify why _____

Other Disposition, explain _____