INTECELLE BEHAVIORAL HEALTH SERVICES

Patient Chart # _____

REFERRAL FORM

Name: _____ Age: _____ DOB: _____ Gender: ☐Male ☐Female
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: (_____) _____ Email: _____
Secondary Phone: (_____) _____ Leave Messages: ☐ Yes ☐ No
If Minor, where does the child currently reside? ☐ Both Parents ☐ Mom ☐ Dad ☐ Joint Custody (Specify below)
Other: _____ Joint Custody Arrangement: _____

Parent/Guardian's Name: _____ Relationship: _____
Current Address: _____ Phone: _____

Parent/Guardian's Name: _____ Relationship: _____
Current Address: _____ Phone: _____
Type of Insurance: ☐ Medicaid ☐ ChildNet ☐ Self Pay
Policy / Member ID: _____
SSN: _____

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Referring Agency: _____ Date: _____
Referral Name: _____ Title: _____
Phone: _____ Fax: _____

Reason for Referral (check all that applies):

	Symptom		Symptom		Symptom		Symptom		Symptom		Symptom
☐	Death	☐	Drug Abuse	☐	Anger	☐	Self-Esteem	☐	Domestic Violence	☐	Child Abuse
☐	Divorce	☐	Custody	☐	Depression	☐	Child Abuse	☐	Family Conflicts	☐	Medication
☐	Sleep Problems	☐	Suicidal Thoughts	☐	Poor Health	☐	Run Away	☐	Social Skills	☐	Mental Illness
☐	Child Neglect	☐	Crime Victim	☐	Financial	☐	Anxiety	☐	Truancy	☐	Homeless
☐	Sexual Abuse	☐	Parenting	☐	Legal Issues	☐	Other	☐			

Service(s) Requesting: ☐ Individual Therapy ☐ Family Therapy ☐ Substance Abuse Counseling
☐ Anger Management ☐ Parenting ☐ Substance Abuse Evaluation
☐ Psychiatric Evaluation ☐ Biopsychosocial
Court Ordered? ☐ Yes ☐ No Court Date: _____ If Evaluation, need by _____

Previous behavioral / mental health treatment: ☐ Yes ☐ No Where: _____ For what: _____
Successfully Completed: ☐ Yes ☐ No Is this referral pending acceptance elsewhere? ☐ Yes ☐ No

Preferences for treatment: Primary Language: _____ Therapist: ☐ Male ☐ Female
☐ Office ☐ Home ☐ School ☐ Morning ☐ Afternoon/Evening
☐ Weekdays ☐ Weekends

Therapist Assigned: _____ Staff Signature: _____

Community Behavioral Health Services for Adults & Children
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