Bloom Behavioral Health Referral Form

Phone: (714) 415-8918 Fax: (714) 716-4433

Referring Agency: ____

Contact Name: ____________________________________ Phone: _____________________________

Address: ____

City/State/Zip: ____

Fax: _____________________________________ Email: ____________________________________

Reason for Referral: ____

____

Patient Information

Child Full Name: ____ DOB: ____/____/_____

Parent or Guardian Name: ____

Home Phone: _______________________________ Cell Phone: _____________________________

Email: _____________________________________ Best Time for Contact: ____________________

Preferred Language: ____

I, ____ (caregiver name) hereby authorize the above referring agency and/or its designated employees to exchange/receive the protected information regarding the individual/patient indicated above with ***Bloom Behavioral Health Inc.*** *and/or its designated employees. I request that the information released pursuant to this authorization be used for the following purposes only:* ***behavioral health treatment for autism****. I understand that this authorization is voluntary. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.*

Signature of Patient's Caregiver/Legal Representative: ____

Printed Name of Patient's Legal Representative: ____

Date: _________________________________

Please send this referral form directly to Lori Aguirre M.A. BCBA, Executive Director. Please send via fax (714) 716-4433 or email Laguirre@bloombh.com. The agency and patient will be contacted within 24 hours from receiving the referral form. Thank you for your referral.