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Behavioral Health Partners

REFERRAL FORM

Please Print

Name: _____

Date: _____ **Phone:** _____

Facility: _____

Facility's address: _____

Person making referral: _____ **Title:** _____

Reasons for Referral (Please check all that apply).

- □ New Admit to Facility
- □ Dementia
- □ Behavioral Issues
- □ Increased isolation
- □ Chronic pain
- □ Diabetes
- □ Taking medications: anti-depressants and anti-psychotics
- □ Changes in sleep, appetite, and weight
- □ Major loss (death of spouse, family member, or roommate)

Additional information and or comment: _____

_____

_____

Please indicate when problem(s) began: _____

_____

_____

In addition to the referral we need the following:

- □ Authorization to Treat Form
- □ Face sheet of patients
- □ Copy of insurance card