Date: _____________ Referral Taken by (MBHS Staff Name): _____

METROPOLITAN BEHAVIORAL HEALTH SERVICES

REFERRAL FORM

Referral Source: _____ Agency: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

Are you currently receiving: [ ] Medication Management [ ] Therapy [ ] PRP
If so, with whom? Agency Name: _____ Agency No.: _____-_____-_____

Patient's Name: _____ DOB: ____________ Age: _____

Highest level of education completed: _____

Sex: _____ Race: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MA Number: _____ SSN: _____

Is this your only type of insurance? [ ] Yes [ ] No Other Insurances: _____

Number of arrests in the past 30 days: _____

[ ] Iraq War Veteran [ ] Afghanistan War Veteran [ ] Veteran

Have patient ever-received service from MMHC in the past? _____ If so, when _____

Does patient have reliable transportation? _____ If so, specify type: _____

Care Taker: _____ Relationship to Patient: _____

Daytime Phone: _____

Are you the legal guardian of this person? [ ] Yes [ ] No

If yes, do you have legal documentation? [ ] Yes [ ] No

If yes, please bring legal documentation in or the child will not be serviced.

Will there be any parties other than the legal guardian bringing the child in for services? [ ] Yes [ ] No

If yes, who? _____

Was an MBHS Authorization Form mailed? [ ] Yes [ ] No

Alternate Contact Name: _____ Phone: _____

Program Requested: [ ] PRP [ ] OMHC
Reason for Referral: _____
_____
Present Substance Abuse Issues: _____

Authorization Information (Office Use Only):
Med ID Patient#: _____ Authorization #: _____ Service Date ___/___/____ - ____/____/____

Name: _____

Patient/Guardian availability for Intake? (Check One)
[ ] Morning [ ] Afternoon [ ] Evening

Type of Insurance? [ ] Medicaid (Health Choice) [ ] Medicaid other than Health Choice

Is the patient pregnant? [ ] Yes [ ] No [ ] Unknown

Have you participated in a Self-Help Group in the last 30 Days?
[ ] Yes [ ] No [ ] Not Available

PRIMARY LANGUAGE (Check One)

How well does the consumer speak English? (5 years old or older)
[ ] Very Well [ ] Not Well [ ] Not At All [ ] Not Available

Does the consumer speak a language other than English at home? (5 years old or older)
[ ] Yes [ ] No [ ] Not Available

If yes, what is this language? [ ] Spanish Other _____

DISABILITY STATUS (Check One)

Is the consumer deaf or do they have serious difficulty hearing?
[ ] Yes [ ] No [ ] Not Available

Is the consumer blind or do they have serious difficulty seeing, even when wearing glasses?
[ ] Yes [ ] No [ ] Not Available

Because of a physical, mental or emotional condition, does the consumer have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
[ ] Yes [ ] No [ ] Not Available

Does the consumer have difficulty with walking or climbing stairs? (5 years old or older)
[ ] Yes [ ] No [ ] Not Available

Does the consumer have difficulty dressing or bathing? (5 years old or older)
[ ] Yes [ ] No [ ] Not Available

Because of a physical, mental or emotional condition, does the consumer have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
[ ] Yes [ ] No [ ] Not Available

PLEASE REQUEST THE FOLLOWING:
1) Copy of Valid Identification Card
2) Copy of Medicaid Card
3) Copy of Physical Exam
4) Copy of SSI or SSDI Letters (If Applied)