BEHAVIORAL HEALTH SERVICES REFERRAL FORM

Date of Referral: _____

Client's Name: _____ Date of Birth: _____

Address:
_____
_____
_____
_____

Insurance Carrier:
_____

Member Name:
_____

Member ID:
_____

Phone: _____

Referring Program/Agency: _____

Referring Staff(s) Name & Contact Information:

Name:
_____
Role:
_____
Phone:
_____
Email:
_____

Name:
_____
Role:
_____
Phone:
_____
Email:
_____

REASON FOR REFERRAL (Therapy and/or Psych Medication Management & List Main Concerns/Diagnoses to be Addressed):

_____
_____
_____
_____

INPATIENT/PHP REFERRALS must also complete the following:

1. Anticipated Discharge Date: _____

2. Is PHP or IOP being recommended? YES or NO (CIRCLE ONE)
   a. If YES, anticipated discharge date from IOP/PHP: _____

   *****IF AFTER CARE RECOMMENDATIONS ARE FOR A HIGHER LEVEL OF CARE (HLOC) STEP DOWN (I.E., RESIDENTIAL, PHP, IOP) - OUR CLINIC WILL NOT ACCEPT THE REFERRAL UNTIL THE HLOC IS SUCCESSFULLY COMPLETED.*****

   ****IF PATIENT HAS AODA—PLEASE SEND OVER ASAM & BAC LEVEL (if applicable)**

3. Is client planning to stay in Brown County area? YES or NO (CIRCLE ONE)
   If NO, please indicate where client plans to go:
   _____

4. Was client established with outpatient behavioral health services prior to admission to HLOC? YES or NO (CIRCLE ONE)
   If YES, where? _____
   Reason client will not be resuming services with pre-established provider(s):
   _____

5. Is client homeless? YES or NO (CIRCLE ONE)
   If YES, will client be going to a shelter? YES or NO (CIRCLE ONE)
   If YES, please have client complete NEWCC's Release of Information (ROI) for which the shelter. (This will assist with effective and efficient care coordination.)

- **ROI FOR REFERRING FACILITY NEEDS TO BE SIGNED AND SENT WITH THIS FORM. IF CLIENT IS HOMELESS AND STAYING AT THE SHELTER, PLEASE HAVE CLIENT SIGN ROI FOR THE SHELTER TOO.**
- **ALL REFERRALS CAN BE FAXED TO 920-437-9480 OR EMAILED TO: BHInbox@newcommunityclinic.org**