Erlanger Community Health Centers
Behavioral Health Services Referral Form

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Date of Referral: ___________

Referral Source

Referring Provider Name _____________________ Agency _______________ Contact Phone # _______________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name ________________________________ Medical Record Number (if applicable) _________________
Address (incl. zip code) ____
Home Phone # ___________________ Cell Phone # ___________________ Social Security # __________________
DOB __/__/____ Sex _______ Race ____________ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐
Insurance Type: ☐ Medical Assistance # _________________ ☐ Medicare ☐ Other _________________________
Emergency Contact Name ___________________ Relationship to Patient _____________ Contact # ____________
Primary Care Physician ______________________ Clinic Name ______________________ Phone #_____________
Current Type of Housing (e.g. group home): __________________________________ Veteran Status: ☐ Yes ☐ No
Potential Transportation Issues? ☐ No ☐ Yes Explain: ____

CLINICAL INFORMATION

Reason for Referral ____
____

Continue PAP Grant ☐ Yes ☐ No Discharge Date __/__/____

Diagnosis (*list confirmed if known, if not list suspected*)
Primary Psychiatry Diagnosis ____
Secondary Psychiatry Diagnosis (including substance abuse) ____
Relevant Medical Diagnoses ____
MAT ☐ No ☐ Yes, if "Yes", type? ____

Past Psychiatric History (hx) and treatment (*please check appropriately*)

Former patient in clinic referred to? ☐ No ☐ Yes, details ____
Hx of violence? □ No □ Yes, details ____
Hx of suicide attempts? ☐ No ☐ Yes, details ____
Hx of psychiatric hospitalizations? ☐ No ☐ Yes, details ____
Previous symptoms and diagnoses ____

Current Psychiatric Treatment & History
Current Symptoms ____
Current suicidal / homicidal thoughts? ☐ No ☐ Yes, details ____
Does patient have a current outpatient mental health provider? ☐ No ☐ Yes, details _________________________
Additional Information____
____

Please include MAR with referral if applicable:

Signature of Referral Source ____ Date / Time _________________