

### Outpatient Behavioral Health Referral Form

*Please fax completed form and recent assessment/evaluations to 828-435-8393, Attn: Referrals*

**Referral Information**

Date: \_\_\_\_\_ Name/Agency: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
\_\_\_\_\_

**Client Information**

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Living Arrangement:  Independent  Family  Group Home  Other: \_\_\_\_\_  
Legal Guardian:  Self  Parent  Family Member  DSS  Other: \_\_\_\_\_  
Legal Guardian Name and Phone: \_\_\_\_\_

Insurance:  Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  Self-Pay

Possible Communication or Language Barriers:  No  Yes: \_\_\_\_\_  
Transportation Barriers:  No  Yes: \_\_\_\_\_

**Referral Reason & Concerns**

Services Requested:  Counseling  Medication Management  Both

Presenting Concerns:  Anxiety  Depression  Mixed Mood  Substance Use  ADHD  
 OCD  Trauma  Behavior Issues  Autism/Developmental  Other: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Recent Hospitalization:  No  Yes; Dates: \_\_\_\_\_  
Safety Concerns (SI, self-harm, aggression, etc.): \_\_\_\_\_  
Court Ordered?  No  Yes; County: \_\_\_\_\_

**Current Mental Health Services**

Agency/Type: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***For Office Use Only***

Referral Source Contacted (Date: \_\_\_\_\_)  Screened (Date/By: \_\_\_\_\_)  
 Accepted  Declined (Reason: \_\_\_\_\_)  Waitlist (Reason: \_\_\_\_\_)  
Follow Up Notes: \_\_\_\_\_