BEHAVIORAL and PSYCHIATRIC HEALTH SERVICES REFERRAL FORM

Service Requested: ☐IHT ☐TT&S ☐TM ☐Medication Management ☐ Outpatient

Referral Date _____/______/________ **Referring Source:** ___________________________

Referral Name:______________________________________ Telephone_______________________

Email____

Member Information:

Member Name _____________________Insurance ________________MMIS#_____________________

Guardian: __________________________Telephone: _ ________________ Cell:___________________

Street _____________________________ City _____________ State______Zip________________

Date of Birth ____/_____/______

Reason for the referral: *(If **CBHI** referral, please ALSO provide brief description of client's behavioral symptoms and impact on daily functioning, and any diagnostic information if available)*

MBHP Eligibility Verified Date: _________________ **Staff Initial**_______

FOR CBHI PROGRAMMATIC USE ONLY

DISPOSITION: Assigned to: ___________________________Assigned Date: ____/_______/______

CBHI ASSIGNMENT CONTACT:

1st contact (must be within 24 hours) Date: ___/_____/_____

2nd contact (first available) Date: ____/_____/_______

3rd contact (start date) Date: ____/_______/_______

Please Return to Administrative Coordinator for Clinical Services

E-Mail: lpremo@centroinc.org or fax 508-798-1914 Attn: Lisa Premo