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BEHAVIORAL HEALTH SERVICES REFERRAL FORM
Mercy Care

RBHA/Provider Referred to: _____ Date of Referral: _____ Referral Source: ☐ PCP/General Medical Provider ☐ DES/DDD ☐ AOC ☐ ADOC ☐ ADJC ☐ ADE Other _____

Type of Service Requested: ☐ **One-Time Consultation** ☐ **Ongoing Behavioral Health Services**

Case Manager/Parole Officer/Probation Officer: _____

Telephone #: _____ Fax #: _____ Supervisor:

Person Making Referral: _____ Telephone #: _____

Address: _____ Fax #: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: _____ DOB: _____

Address: _____ City: _____ State: _____ County: _____

Zip Code: _____ Telephone: _____ AHCCCS ID: _____ Social Security #: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Primary Payment Source: ☐ Self Pay ☐ Medicare ☐ AHCCCS/Other Government ☐ Other Insurance ☐ Other

Other Insurance: ☐ Medicare ☐ AHCCCS ☐ Private ☐ CHAMPUS/VA ☐ Other ☐ No Insurance

Parent/Guardian/Other (if applicable): _____ Daytime Phone #: _____

Address: _____ Primary Language: _____

Person/Parent/Guardian agrees to referral: ☐ Yes ☐ No OK to telephone person/parent/guardian: ☐ Yes ☐ No

Brief history & chief complaint/presenting problem: _____

Check all that apply:

☐ Alcohol Use/Abuse/Dependence ☐ Drug Use/Abuse ☐ Injection Drug User

☐ Pregnant Woman ☐ Woman with Dependent Child(ren) ☐ SEH (Special Ed)

Primary Care Physician: _____ Telephone #: _____

Address: _____ Fax: _____

Date of Last Visit: _____ Last Psychiatric/Medical Hospitalization (if any): _____

Current Medical Problems: _____

Current Medications (psychotropic and general medical): ______________________

______________________ Allergies: ______________________

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FOR RBHA USE: Date of Receipt: ______________ ☐ Crisis ☐ Urgent ☐ Routine

☐ Referred to: ______________ Appointment Scheduled: ☐ Yes ☐ No Date/Time: ______________

☐ Waiting List: ☐ Not Referred for Behavioral Health Services (specify reason): ______________

Person Notified: ______________ Date of Notification: ______________ Person Notified: ______________