ADULT BEHAVIORAL HEALTH REFERRAL

MUST BE 18 OR OLDER

☐ Patient has requested a referral to the ARHS Behavioral Health Program.

Patient Name:_____ **Date of Birth:**_____

Address:_____ **City/State:**_____ **Zip:**_____

Contact: Phone (Cell)_____ **(Home)** _____

☐ Spanish Speaking ☐ Other Language/Please indicate:_____

Insurance:

☐ Medicare ☐ Blue Cross Blue Shield ☐ Tricare *Prior Authorization for PRIME

☐ Optima ☐ Cigna ☐ Medicaid, WellCare, Healthy Blue

☐ None ☐ United Health Care ☐ Other:_____

Service Requested: ☐ LCSW / Counseling Only ☐ LCSW / Counseling and Psychiatrist*

*All patients must receive counseling in order to see the Psychiatrist. Our program provides Psychiatric Evaluation and medication recommendations through a partnership with NC STeP/ECU Psychiatry. The Psychiatrist does not prescribe nor manage medications. Please note, our program is not the appropriate resource to assess/treat cognitive impairment, dementia or intellectual or developmental disability.
We do not provide psychological testing.

Reason for Referral:

☐ Depression ☐ Anxiety ☐ Mood Disorder ☐ Other (note below)

☐ Trauma ☐ Grief and Loss ☐ Bipolar Disorder

_____

_____

Items Required for Referral:

☐ Completed Referral Form ☐ Patient Demographics Sheet ☐ Copy of Insurance Card

☐ Notes from last two office visits ☐ Complete Medication list

PROVIDER NAME (Printed):_____ **FAX:**_____

Signature (required):_____ **NPI:**_____ **Date:** _____

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