Behavioral Health Referral Form

CharmBehavioral

Phone: (972) 632.7015 | Fax: (844) 402-0972

Date: ____/____/____

Patient Information

Patient full name: _____ Gender: ☐ **Male** ☐ **Female**

Current address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Number: _____

Responsible Party: _____ Relationship: _____

Referral Source

☐ **Self** ☐ **RN, LMSW** ☐ **POA** ☐ **PCP** ☐ **Other:** _____

Contact Person: _____ Email: _____

Phone number: _____ Fax Number: _____

Primary Insurance

☐ **Medicare** ☐ **Medicaid** ☐ **Private pay** ☐ **Private Insurance** ☐ **Other:** _____

Group number: _____ ID or Policy Number: _____

Date of birth: _____ Social Security Number: _____

Secondary Insurance

☐ **Medicare** ☐ **Medicaid** ☐ **Private pay** ☐ **Private Insurance** ☐ **Other:** _____

Group number: _____ ID or Policy Number: _____

Symptoms and Behaviors

☐ Anxiety, irritability, or restlessness	☐ Argumentative or Uncooperative	☐ Poor adjustment to a medical condition	☐ Depression
☐ Substance Abuse	☐ Emotional Outbursts	☐ Suicidal Ideation	☐ Bi-polar
☐ Aggressive or disruptive behavior	☐ Exacerbation of health problems	☐ Decline in functioning	☐ Phobias
☐ Sleep problems or disorders	☐ Personality disorder	☐ Self-abuse or mutilation	☐ Impulsive
☐ Social isolation or withdrawal	☐ Danger to self or others	☐ Inappropriate sexual behavior	☐ Schizophrenia
☐ Poor appetite or weight fluctuation	☐ Noncompliant with medical or nursing care	☐ Hallucinations	☐ Other

Chronic Condition

☐ Oncology	☐ Multiple Sclerosis	☐ Muscular Dystrophy	☐ Diabetes

Additional Information

How long has the patient/client had services with you? _____

Is there any potential for violence or harm befalling anyone in the home? _____

Do you have any safety concerns for the client? _____

Are there animals that pose a problem for a visitor in the home? _____

Does the client or someone in the home smoke or abuse alcohol or street drugs? _____

Does the client have any support systems in the home? _____

Additional Information: _____