



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: _____