



Behavioral Health Clinic Referral Form

Date of Referral: _____

Referral Source

Referring Provider Name _____ Agency _____ Contact Phone # _____

Patient Demographics

Patient's name _____

DOB _____ Sex _____ Race _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address (include zip code) _____

Home Phone # _____ Cell Phone # _____ Social Security Number _____

Insurance Type/Name: _____ Member ID: _____

Emergency Contact Name and Phone Number: _____

PCP: _____ Clinic Name: _____ Phone: _____

Reason for referral

Diagnosis: _____

Relevant Medical Diagnosis': _____

Relevant Social Factors: _____

Past Psychiatric history and treatment: _____

Current Psychiatric Medication list: _____

Signature of referral source: _____ Date: _____

Please fax information to Behavioral Health at 307.675.5521.

Please send any relevant documentation and a copy of patient's insurance card.