



Referral for Behavioral Health Services

Member Name: _____ Date of Referral: _____

Medicaid number: _____

Dear Colleague:

I am the primary care physician for the above-named member, who has expressed concern about the issues checked below. A course of treatment ___has ___has not been started under my care.

Current concerns:

- Depressed symptoms, Anxiety Symptoms, ADHD Symptoms, Eating Disorder, Other, Substance Use, Behavior Problems, Developmental Delays, Head Injury, Learning Problems, Hallucinations/Delusions, Mania, Parenting

Current Medications:

Table with columns: Medication, Dose, Frequency, Length of time

See attached list

Medical Problems:

- Diabetes, Asthma, Other

Attached lab results: CBC, Thyroid Studies, Chem. Profile, EKG, Lipid Profile, Serum drug level

Diagnostic Tests: _____

Table with columns: Medical problem, Hospital, Date of admission

PMP Information: Name, Address, Phone, Fax