MDwise BEHAVIORAL HEALTH

Referral for Behavioral Health Services

Member Name: _____ **Date of Referral:** _____

Medicaid number: _____

Dear Colleague:

I am the primary medical provider 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
- ☐ Substance Use
- ☐ Behavior Problems
- ☐ Developmental Delays
- ☐ Head Injury
- ☐ Learning Problems
- ☐ Hallucinations/Delusions
- ☐ Mania
- ☐ Parenting
- ☐ Other _____

Current Medications:

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:

_____

_____

Medical problem	Hospital	Date of admission

☐ **Recent Hospitalizations:**

_____

PMP Information: Name:
Address:
Phone:
Fax: