



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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Depressed symptoms | <input type="checkbox"/> Substance Use | <input type="checkbox"/> Learning Problems |
| <input type="checkbox"/> Anxiety Symptoms | <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Hallucinations/Delusions |
| <input type="checkbox"/> ADHD Symptoms | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Mania |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> 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
<input type="checkbox"/> Recent Hospitalizations:			

PMP Information: Name:
Address:
Phone:
Fax: