BURRELL BEHAVIORAL HEALTH

REFERRAL FORM

Client Name ______________________________ DOB ______________

☐ Male ☐ Female Age ______________

Address ______________________________ County ______________

City ______________ State ____________ Zip ______________

Phone ______________ Alternate Phone ______________ Ok to call ☐ Yes ☐ No

Guardian? ☐ Yes ☐ No If yes, Guardian name ______________________ Relationship ______________

Address ______________________________ County ______________

City ______________ State ____________ Zip ______________

Phone ______________

Current placement ☐ Yes ☐ No If yes, where ______________________________

School ______________________________ Grade ______________ IEP? ☐ Yes ☐ No

REFERRAL INFORMATION ☐ Self ☐ Other ☐ Cox ☐ St. John's

Physician referring ______________________ Facility ______________________

Address ______________________________ County ______________

City ______________ State ____________ Zip ______________

Phone ______________

Presenting Problem/ Reason for referral ____

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INSURANCE INFORMATION

Primary Insurance ______________________ Policy Holder ______________________

Group # ______________________ ID # ______________________

Policy Holder's SSN ______________________ DOB ______________ Employer ______________________

Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

-For office use only-
Appt. Date: ______________ Time: ______________ Doctor: ______________

Patient Notified: Y N

Date Request Sent Back to Referring Physician by Fax: ______________

Fax to: First Time Scheduling – 417.761.5211