

BMH REFERRAL FORM
(Request for Mental Health Services)

Client's Name: (First) _____ (Last) _____

Spouse's Name: (First) _____ (Last) _____

Address: (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip) _____

Gender: M [] F [] D.O.B. ___/___/___ Date Referred: _____ Date Assigned: _____ Therapist: _____

Child(ren) Reside(s) with: Natural Parent(s) [] Foster Parent(s) [] Group Home [] Legal Guardian(s) []

Parent/Guardian Name: _____

Home Telephone: _____ Work Telephone: _____ Alternate: _____

Referral Agency: _____ Contact Person: _____ Tel: _____ Supvr: _____

Pymt: Ins. Name: _____ Med/Cin/P. Ins.# _____ Seq: _____

Insurance Authorization : Yes [] No [] Date: _____ Auth #: _____ # Sessions _____ Auth Period : _____

REASON FOR THE REFERRAL AND PRESENTING SYMPTOMS: (please be specific)

*****PLEASE FORWARD ANY & ALL OF THE FOLLOWING DOCUMENTATION WITH ALL REFERRALS*****

Psychiatric Hospitalization Yes [] No [] Name of Hospital: _____ Date of Discharge: _____

Medication Type: _____ Dosage: _____

Psychiatric _____ Psychological _____ Psychosocial _____ Education _____ Medical _____ Other _____

(PLEASE CHECK ALL THAT APPLY)

Special Language Requirement: _____ Gender Preference: _____

Service Type Request: ** In-Home _____ In-Office _____ Individual _____ Family _____ Anger Management _____ Parenting Skills _____

Appointment Preference: Days _____ Evenings _____ Weekends _____ 10am-1pm _____ 2pm-5pm _____ 6pm-9pm _____

**** IF REQUESTING IN-HOME THERAPY, JUSTIFICATION MUST BE COMPLETED****

Justification For In-Home Services _____

CONSENT FOR EVALUATION AND TREATMENT

I do herewith voluntarily consent to routine diagnostic and therapeutic procedures and treatment to be provided by physicians, treatment staff and other clinical personnel of Beverley Mack Harry Consulting Services Inc. Client Signature: _____

I am signing for the client because: _____ client is a minor unable to consent
_____ other (Explain) _____

Signature of Parent/Agency Representative: _____ Date: _____