Print Form

PM Form 3.3.1
ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES

I. Information on Person Making Referral

Name and Title

Today's Date and Time:

Affiliated Agency

Phone

Fax

Type of Service Requested:

☐ One Time Consultation

☐ Ongoing Behavioral Health Services

II. Information on Person Being Referred for Services

Last Name

First Name

DOB

Gender ☐ F ☐ M

SSN

Home Phone

Cell Phone

Primary Language

Address

City

State

Zip

Current Location (if not above address)

Parent/Legal Guardian (if applicable)

Phone

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (Include phone)

Person/Parent/Guardian is aware of referral ☐ Yes ☐ No

Cultural and language considerations ☐ Yes ☐ No

Is an interpreter needed? ☐ Yes ☐ No

If yes, specify language/need

Special Needs:

Mobility Assistance ☐ Yes ☐ No

If yes, identify assistance needed

Visual Impairment Assistance ☐ Yes ☐ No

If yes, identify assistance needed

Hearing Impairment Assistance ☐ Yes ☐ No

If yes, identify assistance needed

Developmental or Cognitive Impairment ☐ Yes ☐ No

If yes, identify assistance needed

Payment Source:

☐ AHCCCS

AHCCCS # if applicable

☐ Self Pay ☐ Health Plan

☐ Private Insurance ☐ Medicare

☐ Other

PCP

Phone

Fax

Reason for Referral

III. Unable to contact person being referred for services

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? ☐ Yes ☐ No

If no, when will she/he exhaust the current supply of medication?

Number of outreach attempts

Type of Outreach and Engagement conducted (Check all that apply)

☐ Phone Call

Number of calls

☐ Face to face visit attempt

Number of attempts

If unsuccessful, state reason why (check all that apply)

☐ No answer to phone call(s)

☐ Person being referred already enrolled in behavioral health services

☐ Message(s) left with no response

☐ Telephone disconnected

☐ Person being referred refuses behavioral health services

☐ Referral source notified of unsuccessful contact

If this box checked, list alternate contact information obtained

IF UNABLE TO CONTACT - STOP HERE

IV. Information to be completed by network provider

Date/Time Received

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care

Type of appointment

- ☐ Immediate
- ☐ Urgent
- ☐ Routine

☐ Available Intake Appointment Offered

Specify date, time, place

Action taken

☐ Scheduled intake Appointment

Specify date, time, place

☐ Not Referred for Appointment

Specify why

Other Disposition, explain

V. Outcome (within 30 days)

Intake appointment kept ☐ Yes ☐ No

If no, why? Check all that apply

☐ Rescheduled by provider

☐ Rescheduled by person being referred

☐ Cancelled without rescheduling by person being referred

☐ Person being referred was a "No show"

If no show, number of outreach and engagement efforts

Was assessment completed the same day as intake ☐ No ☐ Yes

If no, date assessment scheduled for:

******Please return form to referral source with "Action Taken" Section completed.******

Last revision: 05/08/2009
Last effective date: 07/01/2009