



## Referral to Behavioral Health Facility

DATE \_\_\_\_\_ MID \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ PHONE \_\_\_\_\_

COUNTY \_\_\_\_\_ LEGAL GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

PAYER SOURCE: \_\_\_ Medicaid \_\_\_ Medicare \_\_\_ Health Choice \_\_\_ Private \_\_\_ Self-pay

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency.

Referring Primary Care Provider's name: _____	
Address: _____	Phone: _____
_____	Fax: _____
_____	Email: _____
Arizona Access Referral NPI# (if applicable): _____	

<b>Referral Request:</b> Specific concerns/requests/recommendations:      
---

The following patient information is attached:

- Most recent physical exam
- Medical diagnosis(es)
- Medication list
- Recent lab work
- Pain agreement (if applicable)
- Other:

Signature: \_\_\_\_\_  
(Physician, Physician Assistant, Nurse Practitioner, etc.)

Thank you for agreeing to evaluate this patient.