Behavioral Health Services Referral

Phone: 606-485-4049 F ax: 606-328-5074
Email: Scheduling@resiliencecounselingservices.net

Service Coordination Needed: ❑ Yes ❑ No

Date:	Referring Agency:	Referring Individual:
Notes:		

Please complete as much information as you can, with the **Bold** being most important.

Individual Referred:		Adult Child
Parent name:		Parent DOB:NA
DOB:	Gender: M F	**SSN:**
Address:		School (if child)
City:	State: KY	Zip:
Home Phone:	**Cell:**	**EMAIL:**
Emergency Contact Name:		Phone:

Reason for Referral:		
Diagnosis (If Applicable):		
Insurance Provider:		❑ Commercial ❑ Medicaid
Is there a Secondary policy?		Policy Info:
Member ID:	KMA:	Group #:
Policy Holder's Name:		Policy Holder DOB:

Does this client have Medicare?
Does this client already have Case Management?
Does this client need HOME or SCHOOL appointments? Details.