

Faith & Hope Behavioral Health

112 Catalpa Street Monroe, La 71201
(318) 381-8584 Phone (877) 819-9001 Fax

REFERRAL FORM

Date of Referral: _____

Referring Agency: _____ Referral Clinician: _____

Type of Service Requested: ☐ Mental/Behavioral Health

Last Name: _____ First Name: _____ M.I.: _____ Sex: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone #: _____ Social Security #: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Primary Payment Source: ☐ Medicaid ☐ No Insurance

Parent/Guardian/Other (if applicable): _____ Daytime Phone#: _____

Address: _____ Primary Language: _____

Person/Parent/Guardian agrees to referral: ☐ YES ☐ NO OK to telephone person/parent/guardian: _____

Brief history & chief complaint/presenting problem: _____

Primary Care Physician: _____ Telephone: _____

Address: _____ Fax: _____

Date of Last Visit: _____ Last Psychiatric/Medical Hospitalization (if any): _____

Current Medical Problems: _____

Current Medications (psychotropic and general medical) : _____

Allergies: _____

FOR FHBH USE: ☐ Crisis ☐ Urgent ☐ Routine

Date of Receipt: _____ ☐ Referred to : _____

Appointment Scheduled: ☐ Yes ☐ No Appointment Date/Time: _____

☐ Waiting List ☐ Not Referred for Behavioral Services (specify reason): _____

Person Notified: _____ Date of Notification: _____