CORE Psychiatric & Psychological Services
Referral Request for Evaluation and Treatment

Date/Time of Referral: _____

Caller Name/Phone: _____**Relationship:** _____

Referring Agency/Contact: _____**Phone:** _____

Type of Service Requested: O/P Meds BHRS MMH Therapist Preference: Male / Female

Preferred Location for Services: _____ **Availability:** _____

Prior Client: Y / N Prior to 2019: Y / N Did they see: Doctor / Therapist

Client Name: (First) _____ **(MI)**_____**(Last)**_____
Address: _____**County:** _____
_____
Phone: _____**Leave Message: Y / N Voicemail Setup: Y / N**
DOB: _____ **Under 21: Y / N Under 14: Y / N**

Parent(s) Name(s)_____**Phone:** _____
School Attending: _____

Insurance: Primary_____ **ID:** _____

COPAY: _____ **DEDUCTIBLE:** _____
Secondary_____ **ID:** _____

Social Security No: _____

Reason for Referral *(be specific):*_____
_____
_____
_____

Current Treatment Y / N **Provider:** _____

Substance Abuse: Y / N

If you are in need of immediate assistance, please contact the Crisis Hotline: 1-800-341-5040