CONFIDENTIAL

Behavioral Health Referral Form

Last Name_____ First Name_____ MI_____

Home Address_____ City_____ State_____ ZIP_____

Home Phone_____ Cell Phone_____

D.O.B. _____ Gender _____ Marital Status _____

Social Security Number _____ Preferred Language _____

Race _____ Employment Status _____ Employer_____

Board & Care Name (if applicable) _____ Other Residence Name_____

Caregiver Contact Name_____ Phone_____

Emergency Contact Name _____ Phone_____

Primary Care Dr. _____ Medical Group _____

Primary Insurance Information

Insured Name_____ Relationship to Patient _____D.O.B._____

Insurance Company Name _____

Insurance Company Address _____

City _____ State_____ Zip_____ Phone _____

Policy no._____ Group no._____Employer_____

*Able to Drive? Yes/No

*Needs Transportation: Yes/No

Referral Source _____ Referral Phone Number: _____

DSM-V Psychiatric Diagnosis (if applicable) _____

Additional Medical Diagnoses (if applicable) _____

Chief Complaint/Concern:

_____

_____

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Please Fax This Form To: 760-325-2727 OR email to cmaciel@sgmh.org