MENTAL HEALTH SERVICES
REFERRAL FORM

IDENTIFYING INFORMATION

Client's Name: _________________________ DOB:_____________ Age:___________

SSN#:_________________________Gender:_______________Race:______________

Medicaid Number:________________________ Medicaid Active: ________

Address:____________________________________ City/Zip:______________________

Phone Number: ____

Current Problems and Services:

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Referral Source:

___ OCBS ___ Doctors Office ____Family Member ______ Other_______________

** Client **MUST** have a previous diagnosis by doctor

Diagnosis:____________________________ Doctors Name:_______________________

Person Making Referral:________________________ Contact Number:______________

Mental Health Services Eligible: Yes ____ No _____ Date Checked: _____________

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