Mental Health Services Referral Form
Formulario de referencia de servicios de salud mental

Referral Source Information

Name of Person Referring Patient/Client:		**Date of Referral:**	
Contact Phone #:		**Email Address:**	
Agency / Clinic / Hospital Name:		**Type of Service Requested:**	☐ One-Time Consultation ☐ Ongoing Behavioral Health Services

Patient Information - Información Paciente

Name/Nombre:		**DOB/Fecha de Nacimiento:**	
Sex/Sexo:		**Email/Correo Electrónico:**	
Address/Dirección:		**Telephone#/ # de Telefono**	

Parent/Guardian Information - Información sobre el padre/guardián:

Name/Nombre:		**Language/Lenguaje**	
Email/Correo Electrónico:			

Do you have sole legal decision-making for your child?/ Tiene los derechos exclusivos de tomar decisiones legales sobre el paciente?

☐ Yes/Si ☐ No If not, who?/Si no quien?

If you do not have sole legal decision-making, do you have a power of attorney that is dated within the last six (6) months or court documentation? / Si no tiene derecho de tomar de decisiones legales sobre el paciente, tiene una carta poder fechada en los últimos 6 meses o documentación de la corte?

☐ Yes /Si ☐ No

Note/Nota: Legal Parents or Guardians must consent to enrollment/ El Padre/Guardian legal tiene que dar consentimiento a servicios.

Medical Insurance Information /Informacion de Seguro Medico

☐ AHCCCS	☐ Commercial Insurance/Seguro Comercial	☐ Uninsured/Sin Seguro Medico

Reason For Referral (To be Filled out by Referral Representative)

*Priority: ☐ Routine ☐ Medically Urgent ☐ Consultation ☐ 2nd Opinion ☐ Procedure ☐ Other

*If medically urgent or other, please describe:

Any current or recent history of the patient hurting themselves or hurting others? ☐ Yes ☐ No

Please Scan and Email this form to referrals@livingandbalance.com.

Please include your agency's name in the subject line.

Please be advised that this form is not required, and you can also outreach the Referral team at this email for any questions regarding referrals.