

**PM Form 3.3.1**  
**ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES**

**I. Information on Person Making Referral**

Today's Date and Time \_\_\_\_\_

Name and Title \_\_\_\_\_

Affiliated Agency \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Relationship with Person Being Referred \_\_\_\_\_

**II. Information on Person Being Referred for Services**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  F  M

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Legal Guardian (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (include phone) \_\_\_\_\_

Person/Parent/Guardian is aware of referral:  No  Yes

Cultural and language considerations  No  Yes, specify language/need \_\_\_\_\_

**Special Needs:**

Mobility Assistance  No  Yes, identify assistance needed \_\_\_\_\_

Visual Impairment Assistance  No  Yes, identify assistance needed \_\_\_\_\_

Hearing Impairment Assistance  No  Yes, identify assistance needed \_\_\_\_\_

Developmental or Cognitive Impairment  No  Yes, identify assistance needed \_\_\_\_\_

Payment Source:  AHCCCS ID # \_\_\_\_\_  Private insurance \_\_\_\_\_  Medicare  
 Self pay  Health Plan \_\_\_\_\_

PCP \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Check any of the following which pertain to the person being referred:**

Shows evidence of suicidal or homicidal thoughts or behaviors  Identified need for psychotropic medications

Pregnant Woman  Is currently hospitalized  Was recently discharged from an inpatient setting

Has immediate medical needs  Other potential risk factors, e.g., dehydrated, malnourished, homeless

Reason for Referral, including an explanation of any items checked above \_\_\_\_\_

Additional information and contact information \_\_\_\_\_

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days?  Yes  No, if no, when will she/he exhaust the current supply of medications \_\_\_\_\_

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**III. Information to Be Completed by T/RBHA/Provider**

Date / Time Received \_\_\_\_\_

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care: \_\_\_\_\_

Type of Appointment  Immediate  Urgent  Routine

Available Intake Appointment Offered, specify date, time, place \_\_\_\_\_

Action Taken

Scheduled Intake Appointment, specify date, time, place \_\_\_\_\_

Not Referred for Appointment, specify why \_\_\_\_\_

Other Disposition, explain \_\_\_\_\_