REFERRAL AND RELEASE FORM BEHAVIORAL HEALTH SERVICES

For children and youth, age 20 and under, who may be in need of behavioral health services. Please notify the referring provider if the family has not called for an appointment within 4 weeks of this referral. Please see "Instructions for Pediatric Healthcare Provider Patient Referral for Behavioral Health Services" for Behavioral Health Organization contact information.

Child's First Name: ________________________ Child's Last Name: ________________________

DOB: ___________ ☐ Male ☐ Female Medicaid ID #___________________

Other Insurance: _________________________________

(Foster) Parent or Guardian Name: ____

Address: ____

City: ___________________________ State: ______ Zip: _________ County: _________________

Primary Phone #: ________________________ Secondary Phone #: _________________________

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____________________________

If foster parent, how long has this child been at this residence? ________________________

Assigned DHS Case Worker (if applicable): ____

County: _______________________________ Phone #_____________________________

Referring Medical Provider Practice/Clinic Name: ____

Referring Medical Provider Address: ____

City: ________________________ Phone #: ____________________Fax #: ____________________

Date of last physical/well-child check-up: ____

Has some type of social emotional, developmental, or behavioral screening been completed for this child? ☐Yes ☐No (If yes, please attach a copy to this referral)

What concerns caused this referral?

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Medical Issues/Concerns: ____
____

Medications: ____

RELEASE

I authorize ______________________________ (medical provider referral source) to release the following information (check all that apply):

- ☐ Referral Information
- ☐ Social Emotional/Developmental Evaluations and/or Developmental Screening Results
- ☐ Admissions Summary
- ☐ Discharge Summary
- ☐ Other: ____

This authorization expires on _________________ (expiration date not to exceed 1 year from date of signature).

Signed: ____

Must be signed by parent, guardian or case worker

Date: ____________________________

PLEASE ATTACH YOUR OFFICE HIPAA RELEASE TO THIS FORM