Please leave this box empty

Gila River HEALTH CARE

# BEHAVIORAL HEALTH SERVICES
# REFERRAL FORM

Name of person seeking services: _____

Age: _____ DOB: _____/_____/_____ Gender: M ____ F ____ SS#: _____

Health Insurance: _____AHCCCS #: _____

Mailing Address: _____ District: _____

Location of residence: _____

Home Phone: (  ) _____ Message Phone: (  ) _____

May we contact you at either of these numbers? Y☐ N☐ Best time to contact you? _____

Hospital Chart #: _____ PCP:_____

Currently Pregnant? Y☐ N☐ Veteran? Y☐ N☐ Tribal Affiliation: _____

Are you seeking treatment for? Substance Abuse Treatment ☐ Anger Management ☐ Domestic Violence Classes ☐

Reason for services: _____

_____

_____

Is the need for help urgent? Y☐ N☐ Are you having thoughts about hurting yourself ☐? Someone else ☐ ?

Have you received case management services in the past? Y☐ N☐ When: _____

Has anyone in your immediate family or household received case management services in the past? Who and When:

_____

Do you need special assistance in order to use services? Y☐ N☐ If yes, explain_____

Who suggested that you seek Behavioral Health Services? _____

**If person seeking services is a child, complete the following**:

Parent/Guardian _____

Phone: _____ Are Guardianship papers on file? Y☐ N☐

Address (if different from child's): _____

**Deliver to Behavioral Health Services, New Beginnings Bldg., Shegoi Bldg.,**
**Fax to (602) 528-1374 or email to pgibson@grhc.org**
**Please do not write below this box**

Was Triage indicated? Y☐ N☐ Was Triage offered? Y☐ N☐ Was Triage completed? Y☐ N☐

Intake scheduled with: _____ on _____ at _____

First available intake was _____. Did client prefer another day or time? Y☐ N☐

Gila River HEALTH CARE

# INFORMATION ON PERSON MAKING REFERRAL FOR BEHAVIORAL HEALTH SERVICES

Date: _____

**Contact Information**

Name and Title: _____ Affiliated Agency:_____

Phone Number: (  ) _____ Fax Number: (  ) _____

E-mail: _____ Are Services Court Ordered? Y☐ N☐

**Behavioral Health Services Requested** (Check all that apply)

Outpatient Substance Abuse Treatment ☐ Residential Substance Abuse Treatment ☐ Individual Therapy ☐

Family Therapy ☐ Anger Management ☐ Psychological Testing ☐ (specify need) _____

Domestic Violence Intervention ☐ Psychiatric Evaluation ☐ Medication Monitoring ☐

**Accommodation and Needs**

Mobility Assistance Y☐ N☐ Visual Assistance Y☐ N☐ Hearing Impairment Assistance Y☐ N☐

Developmental or Cognitive Impairment Y☐ N☐

**Block Grant Eligibility:** Substance Abusing Woman with Dependent (young) children? Y☐ N☐

Substance Abusing and Pregnant? Y☐ N☐ IV Drug User? Y☐ N☐

**Please do not write below this box**
**OUTCOME (within 30 days)**

Contact Attempt (types and dates): _____

Appointment Date: _____ Intake Appointment kept? Y☐ N☐

If no, why (Check all that apply) Rescheduled by Provider ☐ Rescheduled by Client ☐ Cancelation by Client without reschedule ☐ Client was "no show" ☐

Outreach attempts made (Check all that apply): Phone call ☐ Letter ☐

Was assessment completed? Y☐ N☐ Notification sent to referral source? Y☐ N☐