



## Preferred Behavioral Health Agency

General Referral Form

Submit completed referrals to: [intake@preferredbehavioralhealthagcy.com](mailto:intake@preferredbehavioralhealthagcy.com)

CLIENT INFORMATION	
Client Name	
Date of Birth	
Age	
Gender	
Race / Ethnicity	
Primary Language	

CLIENT CONTACT INFORMATION	
Phone Number	
Email	
Home Address	
City / State / Zip	

PARENT / GUARDIAN INFORMATION (if applicable)	
Parent / Guardian Name	
Relationship to Client	
Guardian Phone	
Guardian Email	

INSURANCE INFORMATION	
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Insurance Provider	
Medicaid ID Number	
Insurance Group Number	

<b>REFERRAL SOURCE</b>	
Referring Person / Agency	
Referral Contact Email	
Relationship to Client (School / Court / Therapist / Family / Other)	

<b>SERVICES REQUESTED</b>	
Counseling / Therapy	
Intensive In■Home (IIH)	
Peer Support	
Substance Use Counseling	
Case Management	
Other (Specify)	

<b>CLINICAL INFORMATION</b>	
Current Diagnosis (if known)	
Current Medications	
Prescribing Physician	

<b>SAFETY / RISK INDICATORS</b>	
Aggression	
Self■harm behaviors	
Suicidal thoughts	
Substance use concerns	
Family conflict	
Legal involvement	

**Reason for Referral**



**Additional Comments**
