

**ADHS/DBHS Policy and Procedure Manual  
Policy Form 103.1, Referral for Behavioral Health Services**

<b>Information on Person Making Referral</b>
Date: _____
Time (24-hour clock): _____
Type of Service Requested: _____
Name and Title: _____
Affiliated Agency: _____
Phone: _____
Fax: _____
Type of Service Requested: <input type="checkbox"/> One time consultation <input type="checkbox"/> Ongoing Behavioral Health Services

<b>Behavioral Health Services Requested</b>
(Check all that apply): <input type="checkbox"/> Treatment Services: Choose One General description of service(s) requested: Choose One <input type="checkbox"/> Rehabilitation Services: Choose One <input type="checkbox"/> Medical Services: Choose One <input type="checkbox"/> Support Services: Choose One <input type="checkbox"/> Behavioral Health Day Programs: Choose One

<b>Information on Person Being Referred for Services</b>
Last Name: _____
First Name: _____
Gender: Choose One
Home Phone: _____
Cell Phone: _____
Primary Language: _____
Address: _____
City: _____
State: _____
Zip: _____
Current Location (if not address above): _____
If female, are you pregnant?: Choose One
Intravenous Drug (IV) use: Choose One
Parent/ Legal Guardian (if applicable): _____
Parent/ Legal Guardian 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: Choose One
Cultural and Language Considerations: Choose One
If yes interpreter needed: Choose One

<b>Accommodation Needs</b>
Mobility Assistance: Choose One
If yes, identify assistance needed: _____
Visual Assistance: Choose One
If yes, identify assistance needed: _____
Hearing Impairment Assistance: Choose One
If yes, identify assistance needed: _____
Developmental or Cognitive Impairment: Choose One

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Payment Source
AHCCCS: Choose One
AHCCCS ID # (if applicable):
Self-Pay: Choose One
Private insurance: Choose One
Health Plan: Choose One
Medicare: Choose One
Block Grant eligible: Choose One
Other:
Primary Care Physician (PCP):
PCP Phone / Fax:
Name of Private Insurance and/or Health Plan:
Reason for Referral:

Unable to Contact Person Being Referred for Services
If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? Choose One
If no, when will she/he exhaust the current supply of medication?
If currently receiving services will there be any other interruptions that need to be addressed?
Outreach Attempts:
Type of Outreach and Engagement conducted (check all that apply): <input type="checkbox"/> Phone Call Number of calls:
<input type="checkbox"/> Face to Face visit attempts Number of attempts:
If unsuccessful, state reason why (check all that apply): <input type="checkbox"/> No answer to phone call <input type="checkbox"/> Person being referred already enrolled in behavioral health services <input type="checkbox"/> Telephone disconnected <input type="checkbox"/> Person being referred refuses behavioral health services <input type="checkbox"/> Message(s) left with no response
Referral Source Notified of Unsuccessful Contact: Choose One
If yes, list alternate contact information obtained:

**\*\*\*\*If Unable to Contact Stop Here\*\*\*\***

Information to be Collected by Network Provider
Date:
Time (24-hour clock):
If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care:
Type of Appointment: <input type="checkbox"/> Immediate <input type="checkbox"/> Urgent <input type="checkbox"/> Routine
Available Intake Appointment Offered: Choose One
If yes, specify date, time, place:
Scheduled Intake Appointment: Choose One
If yes, specify date, time, place:

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If not Referred for Appointment specify why: <input style="width: 100%;" type="text"/>
Other Disposition , explain: <input style="width: 100%;" type="text"/>

<b>Outcome (within 30 days)</b>
Intake Appointment Kept: Choose One
If no, why (Check all that apply)
<input type="checkbox"/> Rescheduled by Provider
<input type="checkbox"/> Rescheduled by Person being referred
<input type="checkbox"/> Cancelled without rescheduling by Person being referred
<input type="checkbox"/> Person being referred was a "no show"
If no show, specify outreach and engagement efforts (including number of attempts and type): <input style="width: 100%;" type="text"/>
Was assessment completed the same day as intake: Choose One
If no, date assessment scheduled for: <input style="width: 100%;" type="text"/>

**\*\*\*\*Please return form to referral source with "Action Take" section completed.\*\*\*\***

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