Bridgeway
Behavioral Health Services

OUTPATIENT SERVICES REFERRAL FORM

The latest edition of this form may be found at https://www.bridgewaybhs.org/pubs/form.referral.outpatient.pdf

INSTRUCTIONS

This Referral Form is a Fillable PDF. Download and save this form to retain data. For questions regarding Outpatient Services, or this form, call our Access Line at 877-692-5664. Please include any applicable medical or additional records/documents with your referral.

Fax completed form to: < PLEASE SELECT county-specific contact information from this Drop-Down Menu >

REFERRAL SOURCE INFORMATION

Name of Referrer: _____ Today's Date: _____
Referring Agency *(or Relationship to Person Served)*: _____
Referrer Phone: _____ Fax: _____ Email: _____

PERSON SERVED PERSONAL AND DEMOGRAPHIC INFORMATION

Name of Person Served: _____ SSN: _____
Preferred Name to be Called By: _____ Date of Birth: _____
Street Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____ Email Address: _____

Gender: ☐ Male ☐ Female
☐ Gender Fluid ☐ Gender Queer ☐ Non-Binary

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ *(other)* _____ / _____

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American
☐ Pacific Islander ☐ White ☐ *(other)* _____

Marital Status: ☐ Single *(never married)* ☐ Married *(or in a Domestic Partnership)*
☐ Widowed ☐ Divorced ☐ Separated

Is Person Served a Parent of Minor Children under the age of 16? ☐ Yes ☐ No
if "Yes", please list gender/age of each child: _____

Is Person Served a Minor Under the age of 16? ☐ Yes ☐ No
if "Yes", please list Guardian's Name: _____
Cell Phone: _____
and Relationship to Person Served: _____

Religious Preference: _____
Citizen/Immigration Status: _____
Known Allergies: _____

Emergency Contact Name: _____
E.C. Cell Phone: _____
Street Address: _____
City: _____
State: _____ Zip: _____

Criminal Record/Legal Status:
_____
_____
_____

DSM V Codes:
_____
_____

Bridgeway
Behavioral Health Services

REFERRAL FOR: _____

BENEFIT AND INSURANCE INFORMATION

Medicaid # _____	Medicare # _____	PAAD # _____	Private Ins# _____
SSI $ _____	SSD $ _____	Welfare $ _____	Salary $ _____
Pension / VA $ _____	Other $ _____	None _____	Unknown _____

Does person served have a payee? ☐ Yes ☐ No

if "Yes", please list Name of Payee: _____

Street, City, State, Zip: _____

Cell Phone: _____

PRESENTING PROBLEMS

- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Assaultive Behavior / Threat
- ☐ Bizarre Behavior
- ☐ Daily Activities of Living Problems
- ☐ DCP&P Involvement
- ☐ Depression / Mood Disorder
- ☐ Destructive to Property
- ☐ Developmental Disability
- ☐ Domestic Violence
- ☐ Drug / Substance Abuse
- ☐ Eating Disorder
- ☐ Economic Stress
- ☐ Fire Setting / Ideation
- ☐ Homicidal Behavior / Ideation
- ☐ Legal / Justice Involvement
- ☐ Marital / Family Problems
- ☐ Medical / Somatic Concerns
- ☐ No Social Support Resources
- ☐ Organic Mental Disorder
- ☐ Physical Neglect
- ☐ Runaway Behavior
- ☐ Sexual Abuse / Rape Victim
- ☐ Sexual Abuser
- ☐ School-Related Problems
- ☐ Social / Interpersonal
- ☐ Suicide Attempt
- ☐ Suicidal Behavior / Ideation
- ☐ Thought Disorder
- ☐ Other: _____

CURRENT MEDICATIONS (Include Psychiatric, Medical, & any Medication-Assisted Treatments)

Medication:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are receiving MAT at this time, please tell us where you are receiving it from:

_____

HEALTH BACKGROUND INFORMATION

Physical / Medical Conditions / Treatment & Hospitalization:

(Please include date of last physical, and fax or bring documentation to CIBHC)

_____

_____

_____

_____

_____

Bridgeway
Behavioral Health Services

REFERRAL FOR:

HEALTH BACKGROUND INFORMATION (Continued)

Substance Use History / Treatment & Hospitalization:

Psychiatric History / Treatment & Hospitalization:

Veterans History / Treatment & Hospitalization:

PACT Recipient of Services / Treatment:

CSS RIST Recipient of Services / Treatment:

Any other concerns: