Preferred
Behavioral Health Agency

IIH Referral Form

Referral Source Information

Name:

Agency/Organization:

Phone:

Email:

Relationship to Client:

Client Information

Client Full Name:

Date of Birth:

Gender:

Address:

Phone:

Medicaid ID:

Guardian Name:

Guardian Phone:

Presenting Concerns

Reason for Referral:

Diagnosis (if available):

Current Services (e.g., therapy):

Risk Factors (check all that apply):

Emergency Contact Information

Name:

Relationship:

Phone:

Consent and Authorization

[ ] I authorize Preferred Behavioral Health Agency to contact me regarding this referral.

Signature: _____ Date: _____