PM FORM 3.3.1
ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES

I. Information on Person Making Referral Today's Date and Time_____

Name and Title_____

Affiliated Agency_____Phone_____Fax_____

Type of Service Requested: ____ One Time Consultation ____ Ongoing Behavioral Health Services

II. Information on Person Being Referred for Services

Name_____ Date of Birth _____ Gender ☐ F ☐ M

Address_____ Primary Language _____

City_____ State_____ Zip_____ Home Phone_____ Cell Phone _____

Current location (if not above address) _____

Parent/Legal Guardian (if applicable)_____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: ☐No ☐Yes Cultural and language considerations ☐No ☐Yes

Is an interpreter needed , ☐No ☐Yes If yes, specify language/need_____

Accommodation Needs:

Mobility Assistance ☐No ☐Yes, identify assistance needed_____

Visual Impairment Assistance ☐No ☐Yes, identify assistance needed_____

Hearing Impairment Assistance ☐No ☐Yes, identify assistance needed_____

Developmental or Cognitive Impairment ☐No ☐Yes, identify assistance needed_____

Payment Source: ☐ AHCCCS ID #_____ ☐ Self pay ☐ Private insurance ☐ Health Plan ☐ Medicare ☐ Other

Name of Private Insurance and/or Health Plan _____

PCP_____ Phone_____ Fax_____

Reason for Referral _____

III. Unable to contact person being referred

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? ☐ Yes ☐ No, if no, when will she/he exhaust the current supply of medications_____

Number of outreach attempts _____

Type of Outreach and Engagement conducted (Check all that apply)

____ Phone Call Number of calls _____ ____ Face to face visit attempt Number of attempts ____

If unsuccessful, state reason why (check all that apply)

____ No answer to phone call(s) ____ Person being referred already enrolled in behavioral health services

____Telephone disconnected ____ Person being referred refuses behavioral health services ____Message(s) left with no response

____ Referral source notified of unsuccessful contact; if this box checked, list alternate contact information obtained:

_____

IF UNABLE TO CONTACT-STOP HERE

IV. Information to Be Completed by network provider

Date / Time Received _____

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care:_____

Type of Appointment ☐ Immediate ☐ Urgent ☐ Routine

☐ Available Intake Appointment Offered, specify date, time, place_____

Action Taken

☐ Scheduled Intake Appointment, specify date, time, place_____

☐ Not Referred for Appointment, specify why_____

☐ Other Disposition, explain _____

V. Outcome (within 30 days)

☐ Intake appointment kept ____Yes ____No

If no, why? Check all that apply:

___ Rescheduled by provider ___ Rescheduled by person being referred ___ Cancelled without rescheduling by person being referred ___ Person being referred was a "No show"

If no show, number of outreach and engagement efforts _____

☐ Was the Assessment done on same day as Intake? ☐ Yes ☐ No

If no, date assessment scheduled for: _____

******Please return form to referral source with "Action Taken" Section completed.******
