

**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.*****
