REFERRAL FORM
BEHAVIORIAL HEALTH SERVICES

6809 MAIN ST UNIT 953
CINCINNATI, OH
ZIP 45244

Please submit this referral form along with any supporting documents to:

shauna@consult-3e.com
513-809-9320 / 513-813-1908
513-725-1995

Date of Referral:
Referral Source Information:
Name: Title/Position:
Organization/Agency: Phone Number:

CLIENT INFORMATION

Full Name: Date of Birth: Gender: ☐Male ☐Female ☐Other
Address: Phone Number:
Email Address:

Primary Caregiver Information:

Name: Relationship to Client: Phone Number:
Email Address: Home Address:

REASON FOR REFERRAL

Referral for (Check all that apply):

☐Therapeutic Behavioral Services (TBS)
☐Respite Services

Attachments:

☐Client Assessment Report
☐Medical Records
☐Psychological Evaluation
☐Other Relevant Documents (Specify)

Preferred Service Provider:

☐Male or☐Female

Cultural or Language Considerations:

Brief Description of Concerns:

Specific Goals or Needs:

Has the client or legal guardian provided consent for this referral? ☐Yes ☐NO

CLIENT HISTORY AND BACKGROUND

Diagnosis: Previous or Current Services:
Medication:
Relevant Family or Social History:

To be completed by office staff only

Date Acknowledgment Received: Representative Name:
Signature of Representative: