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: _____ Medicaid Number: _____

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

This includes any therapeutic support you currently have

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: _____