Behavior Health Referral

Asociación Latino Americana para la Salud

Date:_____

This person is a current patient at our practice and is in need of a behavior health assessment and/or treatment from your agency:

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Legal Guardian (if patient under 18 years old):_____

Patient/Guardian Phone Number:_____

Payer Source: ☐ Medicare ☐ Medicaid ☐ VA ☐ Self-Pay ☐ Private:_____

Referring Provider's Name:_____ NPI:_____

Practice Name:_____

Practice Address:_____

Practice Phone: _____ Fax:_____ Email:_____

Specific Concerns, Requests, and/or Recommendations:

☐ Check here if additional documentation is attached

Provider Signature:_____ ○ ○ ○ ◉ MD / DO / PA / NP