Red Mountain
Behavioral Health Services

Referral Cover Sheet

Thank you for choosing Red Mountain! Please complete the attached Referral Form and send it along with the documents listed below. Having a complete referral packet will help us to begin services as soon as possible.

Please send the following <u>required</u> documents:

- ☐ 1. Completed Red Mountain Behavioral Health Services Referral Face Sheet
- ☐ 2. T/RBHA Annual Behavior Assessment (reviewed and signed by BHP)
- ☐ 3. T/RBHA Treatment/Service Plan with RMBHS and specific services listed, i.e. The Weekend Retreat, Therapy, Case Management. (signed by BHP <u>and</u> guardian.)
- ☐ 4. Court Order for Guardianship (if the guardian is not the biological parent)
- ☐ 5. Medication Order or Med Plan (signed by prescribing doctor)
- ☐ 6. CALOCUS/SNCD/State Demographics/CFT Note (Case Management only)

This Referral Cover Sheet can also serve as the fax cover sheet for your convenience.

To: Red Mountain Behavioral Health Services Intake Coordination

From: _____

Date Sent: _____

Number of Pages: _____

Phone: 480-641-9552
Fax: 480-981-0893
Email: INFO@rmbhs.com

This fax is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you have received this fax in error please notify the sender and destroy this message.

Red Mountain
Behavioral Health Services

Referral Face Sheet

Referral Date: _____

Please✓the Insurance provider: Gila River ____Mercy Care ____AZ Complete Health ____BUHP ____Other____

REFERRAL INFORMATION

Client Name: _____

Client Phone #: _____

Preferred Language: _____

Other Phone #: _____

Client Address: _____

City and Zip: _____

Address: _____

_____

Social Security #: _____ AND AHCCCS ID#: _____

Client Date of Birth: _____ Gender: _____Client Age: _____

DCS/TSS Legal Guardian?: ☐ **Yes** ☐ **No** If **Yes**, please provide primary care giver's name and Phone #:

_____

Guardian(s) Name: _____

Guardian Phone #: _____

Emergency Contact(s): _____ Phone: _____

Reason for Referral: _____

Diagnosis Code(s): _____

Medications: _____

Allergies: _____

PCP Name: _____ PCP Phone #: _____

Services Requested:

☐ **The Weekend Retreat** (Respite, Life Skills, Family Support, Transportation)

Scheduling Frequency: ☐ Every 2-3 weeks ☐ Once A Month ☐ Only On CM Approval

☐ **Therapy** (Individual, Family, Youth, Adult)

☐ **Case Management** (Low Needs, CALOCUS 1-4)

REFERRING PROVIDER INFORMATION:

Name & Agency: _____ Phone #: _____

Signature: _____ Email: _____