Logo, company name

Description automatically generated

Referral Form

Date of referral:

Referrer’s Information

Name:

Organization:

Phone:

Email:

Individual’s Information

Name:

DOB:

Medicaid#:

Phone:

Address:

Primary MH Diagnosis:

Guardian:       Guardian Contact:

Payee:       Payee Contact:

Briefly state the individual’s situation and need for service:

Please indicate if there is any immediate risk of harm to self or others here:

Anticipated service authorization needs (authorization/tier):

*(Please attach the social history/assessment and any other relevant information, and send to calbaugh@wellserve.health)*