

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)*