External Referral Form

Please ensure that the referral is medically necessary and reasonably expected to improve the client's condition. Include any relevant clinical documentation with this form, and ensure the referral has been discussed with the client prior to submission.

☐ By checking this box, you acknowledge that this referral has been discussed with client and/or legal guardian, and they are willing to participate in the selected services.

Referring Agency Information

Referring Agency/Practice Name

Referring Individual/Provider Name

Phone Number (required)

Fax Number

E-Mail

Client Information

Client Legal Name

Name Client Would Like Used

Phone Number

Date of Birth

Address

Primary Insurance

City

State

Zip Code

Parent/Guardian Name *(if applicable)*

Relationship to Client

Existing Behavioral Health Diagnoses

High Risk Indicators

☐ IV Drug Use ☐ Currently Pregnant ☐ DOC

Referral Information

Reason for Referral: To expedite your referral to the appropriate provider, please be specific with the reason for referral and/or the overall goal.

Behavioral Services Requested:

☐ Outpatient Therapy

☐ Psychiatric Medication Evaluation and Management

☐ Community Psychiatric Rehabilitation (CPR)

Psychological Evaluation/Testing

☐ ADHD ☐ ASD ☐ TBI ☐ Dementia/Memory

☐ PTSD ☐ DID ☐ Psychosis ☐ Behavioral/Learning/ Developmental

☐ GAD ☐ BPD ☐ Bipolar/Mood

Other Services Requested

☐ Substance Use Treatment

Drug of Choice

Frequency of Use *(last 30 days)*

Please submit your referral through one of the following methods*:

Email: Scheduling@burrellcenter.com

Fax: 417-761-5211

A member of our scheduling team will work with your client to coordinate services. If you would like to speak with someone directly, please call **417-761-5000.**

* *Please submit one fax or email per client*

Updated: 02/17/2026