



Referral Form

Referring Agency Information

Referring Agency/Practice

Referring Individual/Provider Name

Phone (Required)

Fax

E-Mail

Client Information

Client Name

Date of Birth

Phone

Address

City

State

Zip Code

Parent or Guardian Name (if applicable)

Relationship

Client Primary Insurance

Existing Behavioral Health Diagnosis

Behavioral Service(s) Requested

Therapy

Psychiatric Medication Evaluation and Management

Community Psychiatric Rehabilitation

Psychological Evaluation/Testing

Diagnosis in question (if requesting Evaluation/Testing)

Other Services Requested:

Substance Use Treatment

Drug of Choice

Frequency of Use (last 30 days)

High Risk Indicators

IV Drug Use

Currently Pregnant and Using

DOC High Risk

Reason for Referral:

Clinical Documentation Included
(examples include: office notes,
lab work, medication list, etc.)

I have discussed this behavioral health referral with client
and/or Legal Guardian, and they are willing to participate in
treatment.

A scheduling representative will work with your patient to coordinate the appointment. You will receive confirmation once the appointment is scheduled.
If you wish to speak to a Scheduling Representative, please call **417.761.5210**.

Please fax or e-mail all documentation to the Burrell Scheduling Office.

Fax: 417.761.5211

E-mail: Scheduling@BurrellCenter.com