BURRELL®
BEHAVIORAL HEALTH

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 Select One: Frequency of Use (last 30 days): Select One:

High Risk Indicators

☐ IV Drug Use ☐ Currently Pregnant and Using ☐ DOC High Risk

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

Please ensure that the referral is medically necessary or otherwise essential to address the client's needs, such as for a legal forensic evaluation, workers' compensation, capacity assessment, or school risk assessment

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

☐ I have discussed this referral with client and/or legal guardian, and they are willing to participate in the selected services

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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