Behavioral Health Department

Please Fax this form to:
Behavioral Health Department
Fax: 203 899-1760
Attn: Behavioral Health Intake Coordinator

Norwalk Community Health Center
Behavioral Health Referral Form

Today's Date: _______________

Patient Name: ____
(Last) (First) (Middle)

Date of birth: ___________________________ Social Security: _____________________________________

Patient's Address: ____
(Street) (City) (Zip)

Mailing Address (If different): ____
(Street) (City) (Zip)

Home Telephone: ____________________________ Cell: _____________________________

Name of Primary Insurance Company: ____

Policy ID#: _______________________________ Group #:_______________________________

Policy Holder Name: ___________________________ Relationship: ___________________________

Policy Holder's Date of Birth: ______________________ Social Security#:______________________

Language Preferred: _________________________ Translation needed? ☐Yes ☐No

Veteran Status: ☐ Veteran ☐ Non Veteran Housing Status: ☐ Homeless ☐ At-risk of being homeless ☐N/A

Case Manager Name: _____________________________________ Telephone: _______________________

Agency Name:_____________________________________ Agency Telephone:_______________________

Behavioral Health services requested: ☐ Individual Therapy ☐ Psychiatric Medication Management ☐Transfer of Care ☐Verification of Disability (VOD)

Current psychiatrist or therapist contact information ☐ I am not established with any psychiatric provider

Name: ____ Telephone: _________________________

Facility Name:____ Facility Address ______________________________

Reason for referral

- ☐ Anxiety
- ☐ Depression
- ☐ Trauma
- ☐ Addiction

- ☐ Substance Misuse
- ☐ Post-Partum
- ☐ High Risk Behaviors
- ____________________

- ☐ High ED utilization
- ☐ Complex Medical
- ☐ Other
- ______________________

Additional comments: ____

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Referred By: _____________________________ _____________________________ Date:____________________
Print Name Title

____
Signature