HOPE AZ Behavioral Health Services
Referral Form

Referral Contact Name ____
Referral Company/Relation____
Contact Phone (_____)____________________
Desired Placement Date____________________________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name_______________________________ Sex ______________ DOB ___/___/_____
Insurance Provider: Δ MercyCare Δ American Indian Health Plan Δ UnitedHealthcare Δ Other __________
AHCCCS ID#_____________________
Emergency Contact Name__________________Relationship to Patient___________Contact # ___________
Primary Care Physician____________________Clinic Name____________________Phone______________

CLINICAL INFORMATION

Reason for Referral: Δ Substance Abuse, last date of use: ___/___/_____ Δ SMI

Δ Mental Health Disorder (Depression, PTSD, etc.) Δ Homeless Δ Other: ______________________________

Diagnosis (IDC 10 Codes) (*list confirmed if known, if not list suspected*)
Psychiatric Diagnosis ____

Past Psychiatric History (hx) and Treatment (*please check appropriately*)
Hx of violence? Δ No Δ Yes, details ____
Hx of suicide attempts? Δ No Δ Yes, details ____
Hx of psychiatric hospitalizations? Δ No Δ Yes, details _____________________________________

Current Psychiatric Treatment & History
Current Symptoms ____
Current suicidal/homicidal thoughts? Δ No, Δ Yes, details ______________________________
Sex Offender? Δ No Δ Yes, details ____
History of Arson? Δ No Δ Yes
Does patient have a current outpatient mental health provider? Δ No Δ Yes, details ______________
Current/Existing Medical Concerns (list or attach any issues with mobility, pre-existing conditions, diabetes, methadone treatment, etc.)
____
____
Current Psychiatric Medications (*name & dose*, attach list if preferred)
____
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Send Form To:
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