SUN-RISE LIVING
BEHAVIOR HEALTH SERVICES, LLC
"THE KEY TO A NEW BEGINNING"

Email: sunriselivingbhs@gmail.com

REFERRAL FORM

Patient's Name: _____ D.O.B.:_____ Date: _____

Social Security#:_____ Gender:_____ Parent/Guardian Name:_____

Address: _____

_____ _____ _____

City, State, Zip Code | Phone Number | Email Address

Are you a returning patient? ☐ Yes ☐ No Access to Transportation: ☐ Yes ☐ No

If yes, what type: ☐ Personal ☐ Public ☐ Medicaid ☐ Friend ☐ Other?_____

INSURANCE INFORMATION

Insurance type: ☐ Medicaid ☐ Medicare ☐ Private/Commercial Insurance ☐ Other ☐ Self-Pay

Insured's Name: _____ Relationship to patient: _____

Insurance subscriber's D.O.B:_____ Place of Employment: _____

Insurance Company Name: _____ Insurance Company's Contact#:_____

Policy #: _____ Group #: _____

SERVICES REQUESTED

☐ PSR (Medicaid Only) ☐ CASE MANAGEMENT (Medicaid/Self-pay Only) ☐ THERAPY ☐ PSYCHIATRY ☐ OTHER

Reason for requested services:_____

_____

What is your preference on how you would like to receive services, if preference is applicable?

☐ Face to face/in person ☐ Office ☐ Home ☐ Community ☐ Other: _____ ☐ Teleheatlh

Clinician's Gender Preference: ☐ Female ☐ Male ☐ N/A

Current Mental Health Diagnosis or Problem: ☐ Yes ☐ No

Current Diagnosis or Problem Description:_____

_____

Have you been hospitalized in the past 30 days? ☐ Yes ☐ No If yes, Where?_____

Do you have your discharge paperwork? ☐ Yes ☐ No

Please list the name of the outpatient facilities(s) in which you received services in the past 12 month?

_____

Name of Primary Care Provider (PCP): _____ _____
Phone Number

Last time you saw your PCP? _____ Last time Medications were prescribed:_____

Name of Pharmacy:_____ _____
Phone Number

List of Current Medications: _____

_____

BELOW IS COMPLETED BY OFFICE STAFF ONLY

Office Staff Only: Was eligibility checked? ☐ Yes ☐ No Insurance Called? ☐ Yes ☐ No

Product Type: _____ Reference#:_____ Therapy Co-Pay Amount: _____

Psychiatrist Evaluation Co-Pay Amount: _____ Psychiatrist Follow up Co-Pay Amount: _____

INITIAL INTAKE APPOINTMENT

Date: _____ Time:_____ Staff Completing Intake:_____

Initial Intake not completed/ Rescheduled: Date:_____ Time:_____ Staff:_____

Referred By:_____ Phone:_____

Was Referral Source Thanked and provided a Patient Status update: ☐ Yes ☐ No ☐ N/A

Name of person receiving update: _____ Date:_____

Referral source: ☐ Fax ☐ Phone Call ☐ Walk-in ☐ Other: _____

- **Intake Schedules: When a patient is referred to Sun-Rise Living from a Crisis Stabilization Unit (CSU), the patient must be contacted within 24 hours, and an intake must be scheduled within 7 days from referral date.**
- **Service treatment plan must be completed within 30 days of referral screening date or 15 days of initial Assessment.**

Patient Provided Intake Packet via: ☐ Sun-Rise Delivery ☐ Postal Mail ☐ Email ☐ Patient Pick up

Date Patient Received Consent Forms: _____

New CID assigned: _____ Office Location Assigned: _____

Referral Form completed by: _____ _____
Print Staff Name Date