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

Email Completed Form to: 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

(Revised July, 2025)

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

This signed Referral Form authorizes SUN-RISE LIVING BEHAVIOR HEALTH SERVICES, to share in verbal OR written communication regarding health records information of the individual to whom it pertains. The *State of Florida* regulates the release of information relating to Psychiatric, Psychological Diagnosis, and Substance/ Alcohol use and HIV/ AIDS. The *State of Florida Regulations* prohibit further disclosure of Mental Health, Alcohol use and HIV/ AIDS related information unless further disclosure of this information is expressly permitted by written consent of the individual or the authorized representative to whom it pertains. ALL information released through verbal, written or electronic communication will be held confidential and according with the *Florida Statutes and Health Insurance Portability and Accountability Act* (HIPAA).

I understand this authorization will remain in effect for a period of one year (commencing on the date this form is signed) and I may revoke this consent at any time. Revocation does not pertain to prior disclosure.

(Revised July, 2025)