REFERRAL TO BEHAVIORAL HEALTH SERVICES SECTION I

Date: _____ MID _____

Patient's name: _____ DOB: _____ Phone: _____
County: _____
Payer Source: ___Medicaid ___Medicare ___Health Choice ___Private ___Self Pay
Legal Guardian: _____ Phone: _____

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency

Referring Primary Care Provider's Name: _____

Practice Name: _____
Address:_____

Phone: _____ Fax: _____ Email:__ _____

Carolina Access Referral NPI # (if applicable) _____

Referral Request

Specific concerns/requests/recommendations:

The following patient information is attached:

- ☐ Medical Diagnosis(es)
- ☐ Most Recent History and Physical
- ☐ Current Medication List
- ☐ Recent Lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Signature: _____
(Physician/Physician Assistant/Nurse Practitioner)

Thank you for agreeing to evaluate this patient.

***** Please fax Section II to the Primary Care Provider listed above. *****

Developed by: Community Care of North Carolina