Date submitted: Enter date Date received: Enter date

**Referred by:**

* Check here is this is a self-referral (client referring for services with no agency)

Agency/Person Name: Enter agency and staff name

Agency Address: Enter agency address

Phone: Enter Phone # Email: Enter e-mail Fax: Enter Fax #

Reviewed by: Enter signer’s name and title

Name & Credentials Signature

Date Enter date

**Referral for:**

Client’s Name: Enter name

DOB: MM/DD/YYYY

AHCCCS#: Enter Participant AHCCCS ID CIS#: Enter CIS ID

Guardian (if applicable) Enter name

Phone: Enter Phone #

Physical address & zip code: Enter physical address

Mailing address & zip code: Enter Mailing address if different from above

If mailing address is the same as physical address, check here:

DX Codes (Axis I) BHC: Enter codes

Client’s Current Status/Location (ie. in the hospital): Enter status

**Additional Information:**

Primary Language Enter information

Method of communication: Enter information

Language needs (ie. American sign-language): Enter information

Race/Ethnicity Enter information

Religious Preference: Enter information

Cultural Preference: Enter information

**Reason for Referral**

Please write a few sentences about the difficulties and issues you would like to discuss or the services you would like to receive: Enter information

What question do you want the psychological evaluation to answer? Enter information

Client’s current living status: Enter information

**Please check below for more detail:**

* Depression
* Stress
* Relationships
* Childhood Issues
* Bereavement
* Family Difficulties
* Domestic Violence
* Eating Disorder
* Alcohol/Substance Use
* Anxiety
* Abuse
* Gender/Sexuality
* Anger
* Self-Esteem
* Self-Harming
* Phobias

**Requested Services: Please check all main & sub service categories requested**

Treatment Services

* BH Counseling & Therapy
* Substance Abuse Intensive Outpatient Counseling
* Assessment, Evaluation & Screenings:
  + Functional Behavioral Analysis and Positive Behavioral Supports (Analytics)
  + Positive Parenting (Analytics Division)
  + Psychological Evaluation

Other, Professional:

* Rehabilitation Services
* Skills Training & Development
* Behavioral Coach
* Cognitive Rehabilitation
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Support Services

* Case Management
* Personal Care Services
* Family Support
* BH Residential Services
* Other

**Required documentation from Referring Agency:**

 Service Plan listing CPES services with BHP Signature

 Current Assessment /BHA and/or most recent Part E with BHP Signature

 Demographic/Face sheet

 Release of Information listing CPES

 Last five CFT/ART note

 Crisis plan

 CASII (for child or adolescent)

 Release of information listing other agencies or individuals involved in care of the client

 Guardianship documents (if applicable)

 Third Party Insurance Card (if applicable)

**For Psychological Evaluation please also provide:**

* Latest update psychiatric evaluation
* Previous psychological evaluations
* Current IEP/School records/testing results
* Progress notes, medications and treatment progress
* Most recent medical, neurological and physical evaluations
* Family history
* DCS and Court reports
* Divorce Decree

**For Out of Home Services, please also provide:**

* Physical (dated within one year)
* TB Test (dated within one year)
* Strengths, Needs and Cultural Discovery
* Psychiatric Evaluation and Progress Notes
* Crisis and safety plan
* History and most recent physical
* Medication History
* Current Risk Assessment
* Current Behavioral Support Plan

**To be filled out by CPES:**

Date Referral Received: Enter date Insurance Verified: Enter date

Indicate if Referral Accepted:

 Yes – First Appointment Date & Time: Enter date

Site/Location: Enter Office Assigned Clinician: Enter name

 No – Reason not accepted: Enter reason