Humboldt Senior Resource Center
Behavioral Health Services

**Send Referral To:**
**HSRC-BHS**
**Fax: (707)443-3498**
**Email:**
**BHS@humsenior.org**

# Referral Form

**Referring individual/entity information:**

Referred by _____ Date _____

Person to contact at referring office _____ Phone _____ Fax _____

**Individual being referred:**

Name _____ Date of Birth _____

Gender _____ Phone Number _____

Address _____

**Insurance information:**

Primary insurance _____Secondary insurance_____

Member ID _____ Group ID _____

**Referral information:**

1. Reason for seeking services (choose all applicable):

| | | | |
|---|---|---|---|
| ☐ Depression | ☐ Grief/Loss | ☐ Life Transitions | ☐ Impulse Control |
| ☐ Anxiety | ☐ Trauma | ☐ Relationships | ☐ Suicidality |
| ☐ Stress | ☐ Substance Use | ☐ Anger Control | ☐ Emotional Management |

☐ Other: _____

2. Please provide a brief description of main concern:

3. Other relevant information:

Medications: _____

Diagnoses (medical/mental health):_____

Past psychiatric hospitalizations:_____

Past treatment history (individual, group, or other therapeutic treatment; medications previously tried):

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***For HSRC BHS office use only***

Has HSRC Behavioral Health accepted this referral? ☐Yes ☐No Reason: _____

Has an appointment been scheduled for this client? ☐Yes ☐No Reason: _____

*CONFIDENTIAL INFORMATION*