Halifax Behavioral Services
Referral Form

Today's Date: _____

Student Name: _____ **Age:** _____ **DOB:** _____

Type of Insurance: _____ **Medicaid Number:** _____

Social Security Number: _____ **School/Grade**: _____

Parent/Legal Guardian Name: _____

Phone: Home _____ **Work** _____ **Cellular** _____

Student's Current Address: _____

_____

Referring Source (Name): _____

Referring Email: _____ **Position**: _____

Phone: _____

Reason for Referral /Description of Issue:

To Be Completed By Provider/Supervisor:

Date Received: _____ **Date Assigned:** _____

Recommendations / Referral notes: _____

_____

Insurance/HMO:
Assigned to:
Assessment:
Targeted Case Manager:
Clinician:

FAX REFERRAL FORM TO (386) 274-1561