1061–Humboldt County Behavioral Health Referral Form

Adult Services/Access Team
720 Wood Street, Eureka, CA 95501
Phone: (707) 268-2900 Fax: (707) 476-4070

Referring office information:

Referred by _____ Date _____

Person to contact at referring office _____ Phone _____ Fax _____

Primary care physician (required) _____

Client information:

Client Name _____ Date of Birth _____
Home Phone _____ Cell Phone _____
Address _____
Name of Conservator _____

Insurance information: (*please provide copies of the front and back of the insurance cards*)
Primary insurance _____ Secondary insurance _____
Medi-Cal ID (if applicable) _____

Referral Information:

1. Referred to HCBH for
   - ☐ Short term counseling
   - ☐ One time medication consultation and return to PCP
   - ☐ Medication consult/treatment until stabilization and return to PCP
   - ☐ Other: _____
2. Reason for current referral:
   - A. Problem _____
   - B. Duration _____
   - C. Frequency _____

   Other relevant medical information:

   _____
3. **REQUIRED** ENCLOSURES
   - ☐ Authorization for Release of Information (to/from), signed by patient or parent/guardian (if applicable).
   - ☐ Most recent Physical exam and lab results, if available.
   - ☐ Current medications, including psychotropic and non-psychotropic, if applicable.
   - ☐ List of previous psychotropic medications tried, if applicable.

SIGNATURE LINE (*name and signature of person completing form*):

Printed Name **Signature & Title/License** **Date**

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

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