NOTE: PLEASE FILL OUT ALL INFORMATION

Attention TBH staff member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral made by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employment Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we send you USPS Mail to the above address: If not please provide mailing address.

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Can we leave message at this number? Y ( ) N ( )

If no, please provide message phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Individual have children? Y ( ) N ( )

If Individual referred is a parent, do they have custody of their children? Y ( ) N ( )

Please List individual’s child or children (Name & DOB):

**Health Insurance (Please circle & attach copy of card):**

**Medicaid:** Presbyterian Western Sky CBS

**Private:** Medicare BCBS Ceridian UNM Tricare Presbyterian United Healthcare Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

**\*\*Discounts for Essential services Can Be Offered, depending upon Family size and Income\*\*\*\***

Primary reason for this referral (check all that apply):

( ) Counseling ( ) FYM ( ) Court Order ( ) Case management ( )Evaluation

( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problem:

Is individual receiving services with another provider: Y ( ) N ( )

If yes where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urgency Estimate: ( ) Emergency, act now ( ) Serious, act in the next 24 hours ( ) Routine, treatment needed

*Taos Behavioral Health Staff Only:*

*Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_*

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*