



Please Fax this form to:
Behavioral Health Department
Fax: 203 899-1760
Attn: Behavioral Health Intake
Coordinator

Norwalk Community Health Center Behavioral Health Referral Form

Today's Date: _____

Patient Name: _____
(Last) (First) (Middle)

Date of birth: _____ Social Security: _____

Patient's Address: _____
(Street) (City) (Zip)

Mailing Address (If different): _____
(Street) (City) (Zip)

Home Telephone: _____ Cell: _____

Name of Primary Insurance Company: _____
Policy ID#: _____ Group #: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder's Date of Birth: _____ Social Security#: _____

Language Preferred: _____ Translation needed? Yes No

Veteran Status: Veteran Non Veteran Housing Status: Homeless At-risk of being homeless N/A

Case Manager Name: _____ Telephone: _____

Agency Name: _____ Agency Telephone: _____

Type of service requested: Individual Therapy Psychiatric Medication Management Transfer of Care

Current psychiatrist or therapist contact information I am not established with a psychiatric provider
Name: _____ Telephone: _____
Facility Name: _____ Facility Address _____

Reason for referral

- Anxiety
- Depression
- Trauma
- Addiction

- Substance Misuse
- Post-Partum
- High Risk Behaviors

- High ED utilization
- Complex Medical
- Other

Additional comments: _____

Referred By: _____ Date: _____
Print Name Title

Signature