Behavioral Health Department

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: _____

Behavioral Health services requested: ☐ Individual Therapy ☐ Psychiatric Medication Management
☐Transfer of Care ☐Verification of Disability (VOD)

Current psychiatrist or therapist contact information ☐ I am not established with any 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