HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

TREATMENT REFERRAL

Please complete this form to refer a patient to an HBI Network Provider or an HBI Staff Provider.

Patient Name:	Date of Birth:
Patient Phone **Home** ☎( ) **Mobile** ( )	ID#:

Insurance Plan: ☐ HPN Smart Choice ☐ HPN Northern Choice ☐ HPN NV Check Up ☐ HPN Expansion ☐ Teachers Health Trust ☐ Others (specify):

Referral Type: ☐ Medication Management ☐ Home Evaluation ☐ Case Management ☐ PSR/BST ☐ Crisis Stabilization Unit ☐ CD-IOP ☐ RTC ☐ Other Therapist

REFERRED TO: ☐ HBI – Las Vegas ➢ Fax (702) 248-1339 ☐ HBI – Reno ➢ Fax (775) 324-1602

Provider Name:_______________ Provider Name:_______________

☐ HBI Network Provider Name: ➢ Fax ( )

WORKING DSM V DIAGNOSIS

Code	Narrative
1)	
2)	
3)	
4)	

PRESENTING SYMPTOMS AND PROBLEMS • REASON FOR REFERRAL

TO ENSURE COORDINATION OF CARE, THIS CASE MUST BE DISCUSSED BY THE REFERRING PROVIDER AND CONFIRMED WITH THE RECEIVING PROVIDER.

REFERRED BY:		
	Provider Name & Title:	Facility:
	Signature of Referring Clinician:	Phone:

Referral Date:	Date discussed with referred provider:	Signature of Referred Provider: ☐ Check if discussed by phone

FOR HBI UM USE ONLY

☐ Authorized ☐ *Declined ☐ *Suspend ☐ *Other Recommendation	*Reason:
Clinical Reviewer Signature:	Date:
Comments:	

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