HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

TREATMENT REFERRAL

Please complete this form when referring a patient to an HBI Staff Clinician or Network Provider.

Patient Name:			Date of Birth:
Patient Phone: (Check preferred contact) ☐ Home ( )			☐ Mobile ( )
Insurance Plan:			ID#:
Referral Type:	☐ Medication Management	☐ Home Evaluation	☐ Case Management ☐ PSR/BST
	☐ Crisis Stabilization Unit	☐ CD-IOP	☐ RTC ☐ Other Therapist
Referred TO:	☐ HBI Children & Family Services ➢ Fax 702-368-7570 Provider Name:		☐ HBI Adult Services ➢ Fax 702-248-0183 Provider Name:
	☐ HBI Medication E/M ➢ Fax 702-248-0183 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 WITH THE CLINICAL SUPERVISOR, AND CONFIRMED WITH THE RECEIVING PROVIDER.

Referred BY:	Provider Name & Title:		Facility:
	Signature of Referring Clinician:		Phone:
Referral Date:		Date discussed with Clinical Supervisor:	Date discussed with Receiving Provider:

▼ FOR HBI UM USE ONLY ▼

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