Behavioral Health Partners

OF FREDERICK

Offsite Counseling Services Referral

Referred by _____ Organization _____ Date _____

Phone # _____ Email _____

I herby grant permission to send this referral to BHP to facilitate outpatient mental health services.

Parent/ Legal Guardian Signature: _____

OR

I received written and/or verbal permission to send this referral to BHP to facilitate outpatient mental health services.

Referrer's Signature: _____

** Biological parents are: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Deceased ☐ Never married

** Is there a court order that establishes custody/guardianship? ☐ No ☐ Yes

***** If YES, please attach the most recent custody paperwork *****

***** The referral process will not begin until we have received it *****

Client name _____ Gender _____ DOB _____

11 digit Medicaid # _____ SS # _____

(this number does NOT have any dashes or asterisks)

Legal guardian _____ Relationship to client _____

Address _____

Home # _____ Cell # _____ Work # _____

Grade _____ School _____ CASS provider _____

(if applicable)

Does client speak English? _____ Does parent speak English? _____

Is an interpreter needed? _____ If so, what language? _____

Reason for this referral: _____

***** This referral needs to be completed in its entirety before submission to BHP *****

Fax referral to 301-682-2596

For questions regarding this referral email us at ocsintake-bhp@sheppardpratt.org

or call 301-663-8263 option #7

BHP Office Use

rcd _____ *ack* _____ *assigned* _____ *acptd* _____