Sheppard Pratt   Outpatient Mental Health Center

Offsite Counseling Services Referral Form

Referred By: ______________________ Organization: __________________________ Date: ______________

Phone Number: _____________________ Email: ____

I hereby grant permission to send this referral to Sheppard Pratt Health System to facilitate outpatient mental health services. *Parent/ Legal Guardian Signature:* ____

OR

I received written and/or verbal permission to send this referral to Sheppard Pratt Health System to facilitate outpatient mental health services. *Referrer's Signature:* ____

Is there a court order that establishes custody/ guardianship? ☐ No ☐ Yes, If yes a copy of the paperwork will need to be provided at the time of intake

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Client Name: _____________________________________ Gender: _______ Date of Birth: _______________

11-Digit Medicaid Number: _________________________________
(This does NOT contain any dashes or asterisks)

Insurance Number/Group: if applicable ____

Legal Guardian: _____________________________________ Relationship to Client: ______________________

Guardian's Email Address: ____

Address: ____

Home Phone: ______________________ Cell: ______________________ Work: ________________________

Grade: ________ Attending School: _______________________________ CASS Provider: _________________
(If Applicable)

Primary Language: ________________________ Is an interpreter needed? _____________________________

Reason for this referral:

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This referral needs to be completed in its entirety before submission

Fax referral to 301-682-2596

For questions regarding this referral, contact us at ocsintake-bhp@sheppardpratt.org or 301-663-8263 ext. 247

Office Use

Rcd: _____________ Ack: _____________ Assigned: ___________________ Accepted: __________________