Riverside University Health System – Behavioral Health

Attachment 16

PROVIDER REFERRAL REQUEST FORM

Date: _____

Type of Plan: ☐ DPSS (ACT) ☐ Group Home/FFA (CARES, CAST) ☐ Medi-Cal / RCHC (CARES)

Provider: _____ Provider #: 33

Provider Phone #: _____ Provider Fax #: _____

Consumer Name: _____ Consumer DOB: _____

Consumer SSN: _____ Medi-Cal #: _____

Consumer Phone #: _____ Caretaker Phone Number(s): _____

Caretaker Name: _____ _____

Primary Language of Consumer: _____ Primary Language of Caretaker: _____

Best Time to Reach Caretaker: _____

Consumer Address: _____

Type of Referral (***This form is to be used ***ONLY*** for additional service referrals. Use Discharge Form if you will no longer be providing any services):

☐ Psychiatric Evaluation Recommended Provider (Optional): _____

☐ Therapy Evaluation Recommended Provider (Optional): _____

☐ County Clinic for all Service Due to Consumer's Severity of Symptoms (Provider to Send Discharge Form)

* Psychological Testing* use Referral for Psychological Testing Form Only

☐ Other: _____ Recommended Provider (Optional): _____

Diagnosis:

ICD 10 Code: _____

_____

Axis I: _____ _____

Secondary _____ _____

Axis II: _____ _____

Axis III:

Axis IV: _____
(Specific Psychosocial Stressors)

Axis V: _____ / _____
Current Highest in Past Year

Reason for Referral(Please describe problematic behavior; be as specific as possible):

Is consumer aware of your desire to refer? ☐ Yes ☐ No

Is consumer (or caretaker) in agreement with referral? ☐ Yes ☐ No

_____ _____
Provider's Signature / Title Date

_____
Provider's Printed Name / Title

Send form to appropriate Authorization Unit

Community Access, Referral, Evaluation, & Support (CARES) * PO Box 7549 Riverside, CA 92513 * Fax: (951) 358-5352

Assessment and Consultation Team (ACT) * PO Box 7549 Riverside, CA 92513 * Fax: (951) 687-5819