



BEHAVIORAL HEALTH SERVICES REFERRAL FORM
Magellan Health Services of Arizona, Inc.
Fax 866.892.5023

I. Information on Person Making Referral
Today's Date _____ Time _____
Name _____ Title _____
Affiliated Agency _____ Phone _____ Fax _____
Relationship with Person Being Referred _____

II. Information on Person Being Referred for Services
Name _____ AHCCCS ID _____ DOB _____ Age _____ [] Male [] Female
Address _____
City _____ State _____ Zip _____ Phone _____
Parent/Legal Guardian (if applicable) _____ Phone _____

Identify individual(s) that the member, parent, or guardian may wish to be invited to initial appointment with person:
Name _____ Phone _____

Person/Parent/Guardian is aware of referral [] No [] Yes
Cultural and language considerations [] No [] Yes, specify language/need _____
Special Needs: Mobility Assistance [] No [] Yes, identify assistance needed _____
Visual Impairment [] No [] Yes, identify assistance needed _____
Hearing Impairment [] No [] Yes, identify assistance needed _____
Cognitive Impairment [] No [] Yes, identify assistance needed _____

Payment Source: [X] AHCCCS Care1st Health Plan Arizona, Inc. [] Private Insurance _____ [] Medicare [] Self pay
PCP _____ Phone _____ Fax _____

Check any of the following that pertain to the person being referred
[] Suicidal thoughts/behaviors [] Homicidal thoughts/behaviors [] Psychosis (i.e. A/H, V/H, Delusions)
[] Need for psychotropic medications [] Currently hospitalized [] Recently discharged from an inpatient setting
[] Has immediate medical needs [] Pregnant woman [] Other potential risk factors (i.e. dehydrated, malnourished, homeless)

Reason for Referral (including an explanation of any items checked above) and/or diagnosis _____

Type of Service Requested [] Emergency Evaluation [] One Time Consultation [] Ongoing BH Services [] Transfer of Care
Additional information/contact information/current medications _____

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? [] Yes [] No
If no, when will she/he exhaust the current supply of medications? _____

III. Information to Be Completed by T/RBHA/Provider
Date Received _____ Time _____
If applicable, name, and contact information of the provider that will assume primary responsibility for the person's behavioral health care:
Name _____ Phone _____

Appointment Type
[] Immediate [] Urgent [] Routine
[] Available Intake Appointment Offered: Date _____ Time _____ Place _____

Action Taken
[] Not Referred for Appointment, specify why _____
[] Other Disposition, explain _____
[] Scheduled Intake Appointment: Date _____ Time _____ Place _____