EXTERNAL REFERRAL FORM FOR SERVICES

☐ **Mother/Baby perinatal Partial Hospitalization Program**

☐ **Outpatient mental health counseling &/or medication management**

Better Beginnings™

14822 Main Street, Alachua, FL 32615

Thank you for referring your patients to Better Beginnings. Please complete this form, then print and **fax to (888) 974-1422.** Please be thorough, as this form will allow us to have all the information required to get the patient started in PHP or outpatient treatment.

If you have questions, please contact us at: (352) 462-9484 **Date of Referral:**

Demographic Information

Name of Patient:		DOB:	
Address:			
Best Contact #:		Email:	

Insurance Information

Insurance Co.:			
ID#:		Group #:	
Subscriber Name:		DOB:	
# To Verify Benefits:			

Referral Source

Referrer Name:		Length of Treatment Relationship:	
Agency			
Phone/Fax		Email:	

How long have you had a clinical relationship with this patient?

Clinical Information

***Please attach relevant testing (must be done 1 week prior to referral date.)**

Perinatal screening score (EPDS, PHQ9, etc.)?

Clinical Goals for

Primary Goal:	
Secondary Goal:	

Current Diagnosis

I:	
II:	
III:	
IV:	
V:	

Previous Mental Health Treatment Programs (include ED, general mental health, substance)

Substance Abuse History (if known):

Alcohol:	
Tobacco:	
Drugs:	
Caffeine:	

Current Medication (Name, dose and frequency)

Medication allergies and adverse reactions:	
Any domestic violence history or current concerns?	
Are you looking for medication adjustments/recommendations?	
If so, preferred communication of changes/recommendations?	

Past Medical History

Any other pertinent social or trauma information

Current Outpatient Treatment (Please include intended prescriber post PHP.)

Psychiatrist:		Dietician:	
Therapist:		Other:	
Primary Care:			

Comments/Other Relevant

Program Staff Approval or Decline (If not appropriate for PHP should they be considered for outpatient?)

Approve: Inpatient _____ PHP _____ Per _____

Decline: Reason and Plan _____

Staff Signature: _____ Date/Time: _____