Client

CMBHS
Clinical Management for Behavioral Health Services

Referral REF043

Referral Date mm/dd/yyyy

Is consent required for this referral? ☐

Receiving Provider

Name/Title

Address Line 1

Address Line 2

Zip Code

City

State

County

Phone Number

Referral Type

Referred By

Appointment Date mm/dd/yyyy Appointment Time hh:mm ○ AM ○ PM

Follow-up required ○ Yes ○ No

Expected Follow-up Date mm/dd/yyyy

Comments

Help Desk: 1-866-806-7806

Referral Outcome

Follow-up Date _____ mm/dd/yyyy

Information Source _____

Client Outcome _____

Presented for Referral

☐ Client Refused ☐ Did not qualify ☐ Put on wait list ☐ Received Services

☐ Scheduled for admission ☐ Other _____

Comments