

**Southwest Alabama Mental Health/Mental Retardation Board, Inc.**  
**PHYSICIAN/CONSUMER/SCHOOL/AGENCY REFERRAL FORM**

(Please Print)

Today's date:	PCP:
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**PATIENT INFORMATION**

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ( )		
					Alternate Phone #: ( )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )		
Referred to Southwest AL MH/MR by (please check one box):				<input type="checkbox"/> Dr. (Please include physician's name)			
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> School			
				<input type="checkbox"/> Agency			
				<input type="checkbox"/> Other			

**REASON FOR REFERRAL**

( Please include current diagnosis if known)

Is this an emergency?  Yes     No (If yes, please call our office or 1-800-239-4673)

Would you like for us to call you today?  Yes     No    If no, what is a convenient time?

**INSURANCE INFORMATION**

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Number:				

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Southwest Alabama Mental Health or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date