Southwest Alabama Mental Health/Mental Retardation Board, Inc.

PHYSICIAN/CONSUMER/SCHOOL/AGENCY REFERRAL FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ 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):			❑ Dr. (Please include physician's name)	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ School
				❑ Agency
				❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Medicaid ❑ Yes ❑ 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.: ( )

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*