LIGHTHOUSE BEHAVIORAL HEALTH & WELLNESS CENTER

Psychiatric Day Program Referral Form

Please email referrals to: referrals@lbhwc.com

Date of Referral: _____ Time of Referral: _____ Client #: _____

(Office Use Only) Assigned To:	Date Assigned:
Intake Date:	Date of First Contact:

Client/Family Name:	DOB:	Gender:
Name of Caretaker:	Relationship to Client:	
Emergency Contact:	Emergency Contact #:	
If client is a minor, who has legal and physical custody:		
Counselor Preferences:	Email Address:	
Address:		
Preferred Phone #:	Alternative Phone #:	
Primary Language:	Interpreter? ☐ Yes ☐ No	Scheduling needs:
Nationality (Country of Origin):	Race:	
School:	Health Center/PCP:	

☐ In-Person Services ☐ Telehealth Services ☐ Hybrid Services

Referral Source Name:		Role with Family/Agency:
Phone:	Fax No:	Email Address:

Insurance Information: **If No Insurance ID, Social Security Number:**

Primary Insurance Plan: _____ Insurance ID #: _____

Secondary Insurance Plan: _____ Insurance ID #: _____

MMIS #: _____ Auth Approval #: _____

Date Authorization Submitted: _____ Date Authorization Approved: _____

Auth Start Date: _____ Auth End Date: _____ Units Approved: _____

Axis 1 (Current Diagnosis Dx Code(s): _____

Who generated diagnosis and when? _____

What are the current concerns or behaviors for the individual/family member (Patient) that led to the referral?

What has been helpful for the individual/family (Patient) currently or in the past? What are their strengths?