Butler Behavioral Health

PROVIDER REFERRAL FORM

FAX: (513) 261-6959
EMAIL: REFERRALS@BBHS.ORG

Provider Information

Name: _____ Email: _____

Agency/Hospital: _____ Phone: _____

Referral Information

Name: _____ SSN: _____

Date of Birth: _____ Phone _____

Address: _____ Parent/Guardian _____

_____ Other Contact # _____

Information _____

_____

_____

Financial Information

Insurance Provider _____ Household Income (Monthly) _____

Member ID/Policy # _____ # Persons in Household: _____

Secondary Insurance Policy#_____ # Persons in Household under 18: _____

Services Requested

- ☐ Individual/Group Outpatient Therapy
- ☐ Integrated Care Management (Health Now)
- ☐ Psychiatric Evaluation/ Pharmacologic Mgt
- ☐ Home-Based Senior Services
- ☐ Vocational Services
- ☐ Intensive Home Based Therapy (WINGS)
- ☐ Early Childhood Services (0 - 8 year old)
- ☐ Mobile Response and Stabilization Svcs (MRSS)
- ☐ School Based Services
- ☐ Home Based Services (children)

Hospital Referrals Only

Client currently inpatient? ☐ Yes ☐ No If yes, date of discharge? _____

Discharge Summary attached? ☐ Yes ☐ No