Outpatient Behavioral Health Referral Form

PH: 937-641-4000 Fax: 937-641-6140
One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request: _____

PATIENT INFORMATION

Patient's Name: _____

☐ M ☐ F DOB: _____

Parent/Guardian Name(s): _____

Home Phone: _____

Cell Phone: _____Work Phone _____

Email address: _____

Preferred Contact Phone: ☐ Work ☐ Cell ☐ Home

Patient is in custody of: ☐ Parents ☐ Guardian ☐ CSB

Address: _____

City: _____ State _____ Zip _____

1st Insurance: _____ID# _____

2nd Insurance: _____ID# _____

REQUESTING PROVIDER GROUP:

Office name _____

Provider name _____

Office location _____

Office contact person _____

Phone _____Fax_____

Signature _____

REASON FOR REQUEST

Diagnosis Code/Reason for request:

_____

_____

_____

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_____

Has the child been psychiatrically hospitalized? ☐ Yes ☐ No

Date of hospitalization: _____ Location of hospitalization, if not Dayton Children's: _____

Reason for hospitalization:

_____

_____

Has the child been diagnosed with autism or a moderate to severe developmental delay? ☐ Yes ☐ No

(PLEASE include ALL applicable clinical documentation to assist in triaging appointment)