



BHC Referral Form

Demographic Information

Name: _____

DOB: _____

Pt SSN: _____

Phone number: _____

Email address: _____

Pt Marital status: _____

Pt Language: _____

Gender: Male Female Other

Race: _____

Military

Military history? Yes No

Military benefits? Yes No

Living Situation

Address type: _____

Address: _____

Zip: _____ City: _____ State: _____

Home phone: _____ Cell phone: _____

Referral:

Referral Source

First name: _____ Last name: _____

Agency or entity referring client: _____

Telephone: _____

Reason for client's visit with referring agency: _____

Reason for discharge at referring agency: _____

What services is the client seeking?

Mental Health Substance Use Housing PRP Psychiatric



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Is client currently enrolled in another program? Yes No

Please select all that apply:

Mental Health Substance Use PRP Methadone Suboxone

Any prescribed medications? If Yes, list.

Date of last refill and how many?

Insurance

Does the client have active insurance?

Medicaid Medicare Self pay

Policy number: _____

Group no: _____

Eff date: _____

BHC Housing Criteria

Registered Sex Offender Yes No

History of fire Setting Yes No

Does the client have any issues with mobility that would interfere with his ability to walk up to a Mile Yes No

Does the client have any open wounds Yes No

History of Seizures Yes No

If so, when was the last episode and are they currently taking any preventive medication

FAX Completed Form to BHC Baltimore: (410) 741-3008 or

Mail to: Preadmissions@bhcbaltimore.com

Behavioral Health Clinic (BHC)

2310 N. Charles St, Baltimore, MD 21218

Thank you ~~for referral!~~ Someone will reach you in next 24-48 hours