FULTON COUNTY BEHAVIORAL HEALTH NETWORK

Telephone (404) 612-6520
Email completed form to fcbhn@fultoncountyga.gov

REFERRAL FORM

PLEASE FILL OUT ALL OF THE REQUIRED FIELDS IN THIS SECTION

Client's Name: (Last) (First) (MI)				**Maiden/Alias**	
Date of Birth (MM/DD/YYYY):	**Age:**	**Legal Guardian:**		**Relationship to client:**	
Gender: Male/Female			**Last 4 of SS#**		
Address:			**City**	**State**	**Zip**
Phone #:	**Alternate #:**		**Email:**		
Primary Language:	**Translation Services needed?:**		**Insurance Provider:**	**Insurance #:**	
Referring Agency:	**Referred By:**		**Contact #:**	**Contact Email:**	

PLEASE FILL OUT AS MUCH INFORMATION IN THIS SECTION AS POSSIBLE

Purpose of Referral (Mental Health, Substance Abuse, Housing, Re-Entry, etc)
Presenting Problem
History of Present Illness
Suicidal/Homicidal statements, threats, gestures? (If yes, provide detail)
Current Medications (please list with dosages)
Current Medical Conditions (hypertension, diabetes, epilepsy, etc)
Current Involvement with Other Agencies (Courts, DFCS, etc)/Other Pertinent Information

Office use only

Time Referral Received	**Date Referral Received**	**Referral Received By**
Referral Sent To	**Accepted/Rejected (if rejected, reason)**	
Client's Appointment Date/Time/Location	**Made by:**	
Any Follow Up Details:		