

**Pediatric Behavioral Health Referral Form and Authorization
for Release of Information**
(Pediatrician → Behavioral Health Colleague)

DATE: _____

REFERRING TO: _____

FAX #: _____

REFERRING PROVIDER: _____

FAX #: _____

CLINIC ADDRESS:

PHONE #: _____

RE: _____

SEX: M F AGE _____ DOB _____

PARENTS/ LEGAL GUARDIAN: _____

PHONE: _____

REASON FOR REFERRAL:

OTHER MEDICAL CONDITIONS/ CONCERNS (_____ NONE)

CURRENT MEDICATIONS (_____ NONE)

DESIRED OUTCOME OF REFERRAL:

- Diagnostic Assessment
- Testing
 - Educational
 - ADHD
 - Diagnostic
- Family Assessment
- Psychotherapy Individual/Family
- Other

TIMEFRAME REQUESTED:

- Urgent
- Semi-urgent
- Routine

Pediatric Behavioral Health Collaborate

By signing this form, I authorize and request that _____ [Name of referring provider1] release my protected health information as identified above for the purpose of treatment with _____ [Name of provider2]. _____ [Name of provider2] will apply its privacy practices and standards to all protected health information that is released or disclosed pursuant to this authorization.

My refusal to sign this authorization may impact _____ [Name of provider2]'s ability to provide treatment. I understand that I may revoke in writing this authorization at any time upon written notice. If not previously revoked, this authorization will automatically expire one year from the date of signature.

Signature of Member

Date

Signature of Parent or Guardian

Date

Pediatric Behavioral Health Response Form

DATE: _____

REFERRING TO: _____

FAX # _____

REFERRING PROVIDER: _____

FAX # _____

RE: _____

DOB: _____

PARENTS / LEGAL GUARDIAN: _____

HEALTH PLAN ID: _____

BRIEF NARRATIVE RESPONSE:

DIAGNOSIS I _____
 II _____
 III _____
 IV _____
 V _____

NEEDS IDENTIFIED:

SUGGESTED TREATMENT PLAN:

FOLLOW-UP VISITS PLANNED Y N

WITH WHOM _____

DATE IF KNOWN _____