

San Tan Behavioral Health Services

Apache Behavioral Health Services/Admission Form/Face Sheet

REFERRAL INFORMATION

Client Name: _____ Referral Date: _____

Client Address: _____ Client Phone: _____
 _____ Race/Ethnicity: _____

Parent/s name: _____ Other Phone #: _____

CPS/TSS Involved: yes no, If yes, name and phone # of CM: _____

Client CIS ID#: _____ Client SS Number: _____

Client Date of Birth: _____ AHCCCS ID #: _____

Gender: _____ Age _____ Preferred Language: _____

Diagnosis Code: _____

Special Needs: yes no, If yes please specify _____

Client allergies/medical conditions: _____

Medications: _____

Emergency Contact: _____ Emergency contact phone # _____

PCP Name: _____ PCP Phone #: _____

Presenting Problem: _____

Services Requested:

- Weekend Respite/Lifeskills
- Young Adult Day Program
- Intensive School Based Programming: specify school _____
- Peer Support Services

Clinical Liaison Name: _____ Signature: _____

Clinical Liaison Phone #: _____

Please ensure that the following documents are sent with this referral, which are licensing requirements:

ADHS assessment

Treatment Plan

Please fax to: San Tan Behavioral Health Services 480-632-0026