

GILA RIVER REGIONAL BEHAVIORAL HEALTH AUTHORITY
AGENCY REFERRAL for Services

Name _____ DOB _____ IHS Chart# _____

REASON FOR REFERRAL / Behavioral Health needs: _____

Social Security # _____ Age _____ Gender F M Tribal Affiliation: _____

Address _____ Dist. _____

City _____ Zip _____ Phone _____ Describe Location of

Residence: _____

Parent/Legal Guardian (if applicable) _____ Phone _____

Person/Parent/Guardian is aware of referral: No Yes

Cultural and language considerations: No Yes, specify language/need _____

Special Needs: Mobility Assistance No Yes, identify assistance needed _____

Visual Impairment Assistance No yes, identify assistance needed _____

Hearing Impairment Assistance No Yes, identify assistance needed _____

Cognitive Impairment No yes, identify assistance needed _____

Check any of the following that pertain to the person being referred:

___ Suicidal or homicidal thoughts or behaviors: **If yes, immediate assessment/intervention is needed.**

___ Identified need for psychotropic medications ___ is currently hospitalized

___ Pregnant Woman ___ has immediate medical needs

___ Was recently discharged from an inpatient setting

___ Other potential risk factors, e.g., dehydrated, malnourished, homeless

If the person is taking behavioral health medications, does she/he have an adequate supply for the next 30 days? Yes

No If no, when will she/he run out of medications? _____

Additional information and contact information: _____

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person

(include phone) _____

Person Making Referral

Today's Date and Time _____

Name and Title _____

Affiliated Agency _____ Phone _____ Fax _____

Relationship to Person Being Referred _____

Information to Be Completed by T/RBHA/Provider

Date / Time Received _____ Appointment Type: Immediate ___ Urgent ___ Routine ___

Available Intake Appointment Offered, specify date, time, place _____

Action Taken: Program type: _____ Intake Worker: _____

___ Scheduled Intake Appointment, specify date, time, place _____

___ not referred for Appointment, specify why _____

___ Other Disposition, explain _____

___ OK to open in CIS If not OK, action taken _____

___ Program enrolled _____ Clinical Liaison/ RC _____

Payment Source: Title XIX Y N AHCCCS ID # _____ Rate Code: _____

KidsCare Y N ID # _____ Eligibility Period – Term. Date _____

Other insurance _____ Medicare _____ self pay _____ Health Plan _____

PCP _____ Phone _____ Fax _____

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GENERAL CONSENT AGREEMENT

To be signed by person requesting RBHA Services . . .

The Gila River Regional Behavioral Health Authority (GR-RBHA) is responsible for ensuring that all individuals with AHCCCS insurance and Kids' Care Insurance have access to appropriate and timely behavioral health care. Through our case management services, our staff will work to understand your and/or your family's current behavioral health care needs. In order to do this, an initial interview is completed and information is collected about the problems you, your children or your family may be experiencing. Additional historical information will be sought from others (e.g., teachers etc.) when appropriate.

The RBHA Clinician may refer you and/or your family members to a treatment provider for counseling, psychiatric medication or other services that you and the staff believe are necessary at this time. In addition, the RBHA clinician/case manager assigned to your family will assist in coordinating services in order to ensure that you receive the quality and timely services that you are entitled to receive.

Records of the GR-RBHA are kept confidential. No persons other than GR-RBHA staff are allowed access to your records without your consent. There are times, however, when we may need to notify others without permission:

1. When a person is dangerous to self or others (i.e., is suicidal or homicidal)
2. When physical or sexual abuse of a child occurs or is suspected
3. When Clinic records are ordered by a court

Your signature below indicates that you understand the above information and consent to the treatment services provided through the Gila River Regional Behavioral Health Authority. Your signature also gives consent to case management services for you and/or your minor child.

Print Client Name

Signature required (parent/guardian signature for a child)

Date

Signature of child/adolescent as applicable

Date

GR-RBHA Data Entry Staff

Date

Deliver to RBHA, New Beginnings building or FAX to 602-528-1374