LEGACY COMMUNITY HEALTH

Behavioral Health Referral Form

Circle your recommended location for Behavioral Health services:

Alief:
Bissonnet Clinic

East End:
Santa Clara Clinic

Fifth Ward:
Fifth Ward
Lyons Clinic

Northline:
Northline Clinic

Montrose:
Branard Clinic
Montrose Clinic

Southwest:
Baker-Ripley Clinic
Mapleridge Clinic
Sharpstown Rookin Clinic
Southwest Clinic

Baytown:
San Jacinto Clinic

Beaumont:
Central Stagg Clinic

Deer Park:
Deer Park Clinic

School Based Health Care:

KIPP Campuses:
Connect
East End
North
Northeast
Sharp
Southeast
Southwest
Sunnyside
Third
Unity

YES Prep Campuses:
Brays Oaks
East End
Fifth Ward
Gulfton
North Forest
Southside
Southwest
White Oak

Galena Park ISD Campuses:
Green Valley Elementary
North Shore Senior High

Referring Agency: ______________________________

Patient Name: ______________________________ Date of Birth: ______/_____/__________

Caregiver's Name (if applicable): ______________________________

Preferred Language: ______________________________ Phone No: ______________________________

Insurance (circle one): Medicaid CHIP Sliding Fee

Insurance Plan HMO/PPO: ______________________________

Please check reason for referral:

- ☐ Aggressive Behaviors
- ☐ Behavioral Problems
- ☐ Developmental Delay
- ☐ Family Relational Problems
- ☐ Individual, Family or Group Therapy
- ☐ Medication Management
- ☐ Screening for ADD/ADHD
- ☐ Screening for Autism Spectrum Disorders
- ☐ Threats of Harm to Self or Others
- ☐ Trauma
- ☐ Treatment of Anxiety
- ☐ Treatment of Depression
- ☐ Other ______________________________

Referral Completed by: ______________________________ Title: ____________________

Phone No. ____________________ Fax No. ____________________ Date: ____________________

Notes Regarding Referral: ______________________________

____

Please fax this form directly to one of the numbers below and we will contact the patient to set up an appointment within 5 business days. Please make sure patient or parent/guardian is aware of the referral prior to faxing the form for appointment. For more information please visit LegacyCommunityHealth.org

Houston/Baytown/Deer Park Area: Phone (713) 351 7360 Fax (713) 351 7361
Beaumont Area: Phone (409) 242 2550 Fax (409) 242 2551