TRUENORTH

BEHAVIORAL HEALTH

PROFESSIONAL REFERRAL FORM

For referrals to Mental Health PHP/IOP, Substance Use PHP/IOP, and co-occurring treatment. Please complete as much information as available. Submission of this form does not guarantee admission; level of care is determined following clinical assessment.

1. REFERRAL SOURCE INFORMATION

Referral Date: _____

Organization/Practice: _____

Referring Professional: _____

Credentials/Title: _____

Phone: _____

Fax: _____

Email: _____

Preferred Contact: ☐ Phone ☐ Email ☐ Fax

2. PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Preferred Name: _____

Pronouns (optional): _____

Phone: _____

Email: _____

Address: _____

City/State/ZIP: _____

Emergency Contact: _____

Relationship/Phone: _____

3. REQUESTED SERVICE / REASON FOR REFERRAL

Requested Program: ☐ Mental Health PHP ☐ Mental Health IOP ☐ SUD PHP ☐ SUD IOP ☐ Co-Occurring ☐ Unsure / Assessment Needed

Primary reason for referral / presenting concerns:

_____

_____

4. CLINICAL INFORMATION

Primary Diagnosis/Concern: _____

Secondary Diagnosis/Concern: _____

Current Therapist: _____

Current Psychiatric Provider: _____

Current Medications: _____

Recent Hospitalization/ER Visit? ☐ No ☐ Yes

Suicidal Ideation: ☐ No ☐ Current ☐ Recent/Past

Homicidal Ideation: ☐ No ☐ Current ☐ Recent/Past

Psychosis/Severe Disorganization: ☐ No ☐ Yes

History of Self-Harm: ☐ No ☐ Yes

Substance(s) Used: _____

Last Use / Frequency: _____

Withdrawal/Detox Concern: ☐ No ☐ Yes ☐ Unsure

Current Recovery Supports: _____

5. INSURANCE / PAYMENT INFORMATION

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Subscriber Name/Relationship: _____

Private Pay Inquiry: ☐ No ☐ Yes Authorization already obtained? ☐ No ☐ Yes ☐ N/A

6. ADDITIONAL INFORMATION & RECORDS

Records available/attached: ☐ Assessment ☐ Discharge Summary ☐ Medication List ☐ Labs ☐ Psychiatric Evaluation ☐ Other: _____

Additional information, safety considerations, accessibility needs, or preferred admission timing:

_____

_____

7. REFERRAL ACKNOWLEDGMENT

I am referring this individual for evaluation by TrueNorth Behavioral Health. I understand that admission and level-of-care decisions are based on clinical assessment, program criteria, patient needs, safety, and applicable payer requirements.

Referring Professional Signature: _____ Date: _____

SUBMIT REFERRALS

Admissions Phone: (214) 919-0305 | Secure Fax: _____ | Email: info@truenorthbhc.com

TrueNorth Behavioral Health • Irving, Texas • Mental Health | Addiction | Recovery | Wellness

For emergencies, call 911 or go to the nearest emergency department. For suicide, mental health, or substance use crisis support, call or text 988.