MORRIS HEIGHTS HEALTH CENTER / HARRISON

*57 W. BURNSIDE AVE. * BRONX, NEW YORK 10453* (718) 839-8900 EXT: 3200*

Behavioral Health Referral Form

REFERRAL FOR SERVICES

Name	**Address**
Phone Home: Cell:	**Date of Birth**
Social Security Number	**Sex** □ Male □ Female
Payment Information: ☐Self-Pay ☐Medicaid ☐ Medicaid HMO (specify HMO) ____________ ☐Other:_______________ ID#____	**Emergency Contact Information** Name: ____________________________________ Relation: ________________ Phone: ______________________________
Name of person making referral: Phone:	Agency:

Reason for referral (please be specific regarding any or all of the following behavior: (mental/emotional state, medical diagnosis, violence, family situation, change in routine, etc.):

Please use as much space as needed:

Do you have specific concerns about potential for injury to self or others, or possible abuse and/or neglect?

_____ Yes _____No (If Yes, please describe)

Please use as much space as needed:

Signature : ____ Date:___________________

Information required with referral:

* Medical Documentation
* Psycho-Social/Intake
* Psychiatric Evaluations
* Current Medication List

Please forward this referral and all other documents to **Emily Ortiz Fax: 718-228-5134 or Email at mhreferrals@mhhc.org**

MHHC office use only:

Screening appointment: ____________________ ☐ Showed ☐ N/S ☐Canceled ☐Rescheduled