



Halifax Behavioral Services Referral Form

Today's Date: _____

Student Name: _____ Age: _____ DOB: _____

Type of Insurance: _____ Medicaid Number: _____

Social Security Number: _____ School/Grade: _____

Parent/Legal Guardian Name: _____

Phone: Home _____ Work _____ Cellular _____

Student's Current Address: _____

Referring Source (Name): _____

Referring Email: _____ Position: _____

Phone: _____

Reason for Referral /Description of Issue:

To Be Completed By Provider/Supervisor:

Date Received: _____ Date Assigned: _____

Recommendations / Referral notes: _____

Insurance/HMO: _____

Assigned to: _____

Assessment: _____

Targeted Case Manager: _____

Clinician: _____

Please NOTE: Agency Fax Number for Referrals: 844-649-6699