BURRELL®
BEHAVIORAL HEALTH

Referral Form

Referring Agency Information

Referring Agency/Practice

Referring Individual/Provider Name

Phone (Required)

Fax

E-Mail

Preferred Method Of Contact

Patient Information

Patient Name

Date of Birth

Address

City

State

Zip Code

Phone

Alternate Phone

Parent or Guardian Name (if applicable)

Relationship

Patient Primary Insurance

Patient Secondary Insurance

Referral Information

Service(s) Requested

- ☐ Therapy
- ☐ Substance Use Treatment
- ☐ Other
- ☐ Psychological Evaluation/Testing
- ☐ Psychiatric Medication Evaluation and Stabilization
- ☐ Community Psychiatric Rehabilitation
- ☐ Psychiatric Medication Consult

Current Mental Health Concerns/Symptoms

Clinical Documentation Included ☐
(examples include: office notes, lab work, medication list, etc.)

I have discussed this mental health referral with patient/family, and they are willing to participate in treatment. ☐

A scheduling representative will work with your patient to coordinate the appointment. You will receive confirmation once the appointment is scheduled. If you wish to speak to a Scheduling Representative, please call **417.761.5210**.

Please fax or e-mail all documentation to the Burrell Scheduling Office

Fax: 417.761.5211
E-mail: Scheduling@BurrellCenter.com