BANYAN
HEALTH SYSTEMS

Patient Referral Form

Referrers Information

Name _____ Organization _____

Date ___/___/___ Email _____

Relationship to Patient Being Referred _____

Patient Information

Full Name _____ Phone _____

Date of Birth ___/___/___ Social Security Number _____

Street Address _____ City _____ Zip _____

Preferred Language for Assessment _____

Preferred Language for Services _____

Has a Consent to Release or Obtain Protected Health Information been attached to referral? ◯ Yes ◯ No

Is this referral being made to support a discharge plan? ◯ Yes ◯ No

If yes, has a copy been provided? ◯ Yes ◯ No

If patient is a minor, please fill out the following section:

Parent or Guardian Full Name _____ Phone _____

Name of School _____ Grade Level _____

Reason for Referral (Check all that apply & include additional concerns below)

- [ ] Mental Health
- [ ] Susbstance Abuse
- [ ] Primary Care
- [ ] Court Order (please attach)
- [ ] Case Management
- [ ] Peer
- [ ] Other _____

Program/Service Requested

- [ ] Counseling
- [ ] Case Management
- [ ] Drug Court
- [ ] Care Coordination Team
- [ ] Medication-Assisted Treatment
- [ ] Psychiatrist
- [ ] Resident Level II
- [ ] Moral Recognition Therapy Group
- [ ] Other/Don't Know

Patient Insurance Information

Does the patient have insurance? ○ Yes ○ No

Insurance Company _____

Policy Number _____ Member ID _____

Preferred Location for Service of Patient

- [ ] **Broward**
(1061 W. Oakland Park Blvd)
intake@banyanhealth.org
Phone: (954) 327-4060
Fax: (786) 312-1371

- [ ] **Flagler**
(3733 Flagler)
3773intake@banyanhealth.org
Phone: (305) 774-3300
Fax: (305) 442-0482

- [ ] **Little Havana**
(3850 Flagler)
3850intake@banyanhealth.org
Phone: (305) 774-3400
Fax: (786) 235-8946

- [ ] **Cutler Bay**
(10720 Caribbean Blvd)
cutlerbayintake@banyanhealth.org
Phone: (786) 293-9544
Fax: (786) 293-9594