BANYAN
HEALTH SYSTEMS

# Patient Referral Form

## Parent or Guardian Information

Name

Date ___ / ___ / ___ Email

Relationship to Patient Being Referred

## Patient Information (Child's Name)

Full Name Phone

Date of Birth ___ / ___ / ___ Social Security Number

Street Address City Zip

Preferred Language

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

☐ Mental Health ☐ Substance Use ☐ Primary Care ☐ Other

## Patient Insurance Information

Does the patient have insurance? Yes No

Insurance Company

Policy Number

Member ID

## Preferred Location for Service of Patient

| Broward | Cutler Bay | Little Havana | Flagler |
|---|---|---|---|
| (1061 W. Oakland Park Blvd) | (10720 Caribbean Blvd) | (3850 Flagler) | (3733 Flagler) |
| intake@banyanhealth.org | cutlerbayintake@banyanhealth.org | 3850intake@banyanhealth.org | 3773intake@banyanhealth.org |
| Phone: (954) 327-4060 | Phone: (786) 293-9544 | Phone: (305) 774-3400 | Phone: (305) 774-3300 |
| Fax: (786) 312-1371 | Fax: (786) 293-9594 | Fax: (786) 235-8946 | Fax: (305) 442-0482 |