FAU COMMUNITY HEALTH CENTER
Christine E. Lynn College of Nursing
Florida Atlantic University

FAU DIABETES EDUCATION AND RESEARCH CENTER
Christine E. Lynn College of Nursing
Florida Atlantic University

# ***Referral for Mental Health Services***

Referring Institution/Provider:_____

Patient's Name:_____ Date of Birth_____/_____/_____

Address:_____

Home:_____ Cell:_____

Insurance _____Insurance #_____ Authorization# _____

Does Client have a current documented mental health diagnosis? YES NO If yes, describe

_____

**PLEASE ATTACH SUPPORTING DOCUMENTS WITH THIS REFERAL**

Check ALL that apply:

_____Mood (Depression/Anxiety)

_____Behavior Issues/ Concerns

_____Medical Health Concerns

_____Legal Issues (DJJ,DCF)

_____Substance Use/ Abuse

____Developmental Needs

_____ School- Related Concerns

_____ Danger to self or others

_____ Concrete Needs (housing, community resources)

_____ Vocational Needs/Independent Living

_____ Safety Concerns

_____ Other: _____

Please list any psychotropic medication, including dosage:_____

_____

Referring provider: _____Signature:_____ NPI: _____

Any Known Medical Conditions:_____

Any known Allergies:_____

Any known family history of Mental Illness_____

Any legal history or DCF cases pending_____

I understand that this form may be faxed by_____to the FAU Community Health Center for the purpose of Mental Health services. I understand that this authorization will expire one year after I have signed this form and that I may revoke this authorization at any time. I have been informed that the party faxing this form will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____

Signature of Patient/Legal Guardian an

1650 Osceola Drive West Palm Beach, FL 33409 561-803-8880 Fax: 561-803-8899