DATE OF 1st CALL:
1st APPOINTMENT:

Referral Form for Mental Health Services

Client Information

Birth/Legal Name:	Preferred Name:	Date of Birth:	Race/Ethnicity:
Gender: ❐ Male ❐ Female ❐ Transgender ❐ Other________________			
Services Requested: ❐ Counseling ❐ Case Management			
CONTACT NUMBERS:		Message ok? ❐ Yes ❐ No	
ADDRESS:			

Payment Information:

Type of Insurance	
❐ Medicaid#____________________ ❐ Ryan White ❐ BCBS Group#__________________ ❐ Other	
Insurance ID#	Phone #

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name/Agency	Mailing Address
Phone#	Email address

Client Mental Health Information:

Current medication & dosage **(If Known)**	
	Current Mental Health Diagnosis:
	Substance Abuse Diagnosis:
	Major Medical Conditions:
Prescribing Physician name & Phone	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
History of Suicide (explain below)					
Psychotic Behavior (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, briefly describe the client in need for mental health services.

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Additional Comments ____

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Mental Health Treatment History:____

Availability:____

Counselor Preferences:____

<u>Please Attach:</u>

___ HIV Verification

___ CD4 & Viral Load

___ Income Verification

___ Photo ID

___ SS Card

___ Birth Certificate

Send Referral To:
3521 7th Avenue S., Birmingham, AL 35222
Phone (205) 324-9822 – Fax (205) 918-8226
destini.love@aidsalabama.org
earlethea.coleman@aidsalabama.org