Hartford HealthCare
Behavioral Health Network

Backus Center for Mental Health – External Referral Form

I) Patient Demographics:

Legal Name: _____Date of Birth: _____SS# _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Primary Language: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

II) Medical Coverage:

Primary Insurance: Insurance Carrier: _____Subscriber: _____

Policy #: _____ Group #_____ Insurance Comp Phone #: _____

Secondary Insurance: Insurance Carrier: _____Subscriber: _____

Policy #: _____ Group #_____ Insurance Comp Phone #: _____

III) Current Diagnosis and Medications: (Please list all psychiatric diagnosis and medications that are known)

Diagnosis:_____ **Medications/Dosage**:_____

_____ _____

_____ _____

_____ _____

IV) Reason for Referral: (Please provide a brief summary of the reason for referral)

_____

_____

_____

_____

V) Services Requested (Check all that apply): **CMH does not provide med management only. Therapy is required.**

☐ Outpatient (Medication Management and Therapy)
☐ Partial Hospitalization Program (5 days per week, 4 groups per day)
☐ Intensive Outpatient Program (3 days per week, 3 groups per day)
☐ Med Assisted Treatment (MATCH)
☐ Men's Health
☐ Women's Health

VI) Contact Information:

Referral Contact: _____ Phone: _____
Referring Agency: _____ Fax: _____

Who should we contact to follow-up with this referral? ☐ Client ☐ Referral Source (Release needed)

Client Signature: _____ Date: _____

Notice: Referral is not valid unless accompanied by a signed Release of Information. Please attach W-10, discharge summary, assessments or office notes, if applicable. Send referral to 860-823-6547 Attn: Referral