REFERRAL REQUEST FORM

Att. Admissions Coordinator
Telephone: 321-236-1540
Fax: 321-594-6096
Email: Referral@SCARFFL.com

Thank you for this referral. For assistance to complete this form, please call. Otherwise, fill in all requested information below and email or fax the referral form to us. Fax to: 321-594-6096 / email to: Referral@SCARFFL.com. You will receive confirmation once this request has been processed. If this is an Urgent Request, please call us immediately at (321) 236-1540. All referrals after 4:30PM will be processed the next business day.

Priority Need: Routine (3 to 7 days) ☐ Urgent (24 to 72 hours) ☐ County: _____ Today's Date: _____

Referrer Information: Agency or Person: _____

Referring Contact: _____ (Phone #) _____ (Email) _____ (Fax)

Primary Doctor: (if different from above) _____ (Name) _____ (Phone #) _____ (Address)

Patient Information:

☐ Female ☐ Male Interpreter Required?: ☐ YES ☐ NO _____ (Patient Language (if other than English)) _____-_____-_____ (Patient Social Security #)

_____ (Patient's Last Name) _____ (First Name) _____ (M.I.) _____ _____ _____ (DOB)

Patient's Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Alternate Phone: _____

Guardian Name : _____ Guardian Relationship: _____

Diagnosis/Presenting Problem (this section must be filled out): _____

Reason for Referral (may check more than one services):

☐ Targeted Case Management ☐ Counseling/ Therapy ☐ Psychiatric Services ☐ Anger Management Classes

☐ Psychosocial Rehabilitation ☐ CBHA ☐ Parenting Classes ☐ Family Preservation Services

☐ Family Visitation ☐ CMS /Outpatient therapy ☐ Substance Abuse Evaluation ☐ Mental Health Evaluation

☐ Adolescent Outpatient Substance Abuse ☐ Other (please explain) _____

Insurance Information:

☐ Medicaid ☐ Medicaid-HMO ☐ PPO ☐ Self-Pay ☐ CMS ☐ OTHER _____

Name of Insurance Plan: _____ Insurance ID #: _____

Medical Group #: _____ Insurance Phone #: _____

Non-Insured/ Non-Medicaid/HMO: ☐ FSPT ☐ TANF ☐ CHS ☐ CBC ☐ Other _____

Requires Authorization? ☐ YES ☐ NO Auth #:_____ # of Visits: _____ Auth Exp Date: _____

Special Instructions:

☐ Attendance/ Participation Notes Needed ☐ Court/ Expert Witness ☐ Certification of Completion

☐ Counselor Availability for Conference ☐ Assessment Report/s Needed ☐ (LOC) Outpatient Discharge (TCM)