**Lighthouse Behavioral Health Center, LLC**

***Referral Form***

Date of Referral:

**Service Requested:** [ ]  Outpatient Therapy [ ]  Intensive In-home/ Home-based Counseling

[ ]  Mental Health Skill-building [ ]  Parent Coaching and Support [ ]  Virtual Residential

[ ]  Integrated Adult Services [ ]  Other (please specify):

**Demographics:**

Prospective Client Name:

[ ] Male [ ] Female

Date of Birth:

Age:

Full Address:

Phone #:

Social Security #:

Legal Guardian:

Relationship to Client:

**Insurance:**

[ ]  Medicaid:

[ ]  HMO/PPO: Choose an item.

ID #:

Policy Holder (if not self):

**Referral Information:**

Referring Individual:

Referring Agency:

Address:

Email:

Phone #:

Fax #:

**Presenting Needs / Need for Service:**

Referral source’s preferred choice of contact for care coordination: [ ]  Telephone [ ]  Secured Email [ ]  Monthly Reports [ ]  No Contact Needed

**Person Completing Referral**:

**Date**:

\*To submit this referral form, you can email it to robynjennings@lbhc.org or fax it to (804) 447-6383. You will be notified the same day to confirm that the email/fax has been received. If you are not notified, please contact the office at (804) 447-6382.