GeorgiaBehavioral HEALTH PROFESSIONALS

By faxing this form, you are representing that the referring clinician has obtained the appropriate consent of the below named patient to share their information with GBHP and to have GBHP contact the patient to evaluate clinical treatment options.

PATIENT INFORMATION * = Required Field

Patient Name: *		Date of Birth: (mm/dd/yyyy):*	SS #: *
Primary Phone: *		Alternate Phone:	Gender: *
Address: *			
City: *		State: *	Zip: *
Insurance Name/Plan: *	Member Services ID:	Carrier's Direct Phone # for Behavioral Health:	
ID #: *		Group #: *	Effective Date:
Policy Holder Name: *		Date of Birth: (mm/dd/yyyy):	Relation to Patient:
Reason for Admission: *			
Primary Diagnoses: *	Mental Health Medications: *		Discharge Date: *
Past or current issues with substance use? (*If yes, which substance(s)*): *			
Specific Requests?			

GBHP intake staff will try to honor a patient request; however, requests may not always be feasible due to availability, location, etc.

REFERRAL INFORMATION:

Referring Practice/Physician: *	Department:	Phone #:
Email Address:	Fax Number: *	
Primary Care Physician:		

APPOINTMENT REQUESTS (please check all that apply): *

Evaluate and Treat ☐ Medication Management ☐

Assessment for Intensive Outpatient Program ☐ Occupational Therapy ☐

Individual Therapy ☐ Nutritional Counseling ☐

Psychological Testing ☐

FOR GBHP USE ONLY

Appointment Date: _____Time: _____Provider:_____ Location:_____

Appointment Date: _____Time: _____ Provider:_____ Location:_____

For additional questions, please call the Georgia Behavioral Health Professionals at 678-820-7868. Thank you for referring.

FAX NUMBER: 470-239-6329