Agape Youth Behavioral Health
Referral Form

Referring Provider Office Name/Practice/Provider Name:

_____

Referring Provider Phone Number:

_____

Referral Contact Person:

_____

Referring Provider Fax Number:

_____

Patient Full Name & DOB:

_____

Patient Full Address:

_____

Primary Language:

_____

Will translation services be needed?

_____

Legal Guardian of Patient Full Name & DOB:

_____

Legal Guardian's Best Contact Number:

_____

Patient's PCP, if different from above:

_____

Patient's Insurance Policy Name & Member ID:

_____

Policy Holder's Name & DOB:

_____

Brief description of symptoms requiring this referral and current diagnosis:

_____

If Patient is currently taking medications, please list name(s) and dosage:

_____

Please select the following service(s) that will meet the need(s) of your client (more than one may be selected).

☐ Medication Management	☐ Individual Therapy	☐ Psychological Testing (Cash Only, $1500-2000)

Location Preference:

☐ East Brainerd Only	☐ Hixson Only	☐ Lee Hwy Only (CPC)	☐ Any Location (Shortest Wait)

If medication management is requested, please select the preferred provider(s). More than one may be selected, requests not guaranteed.

☐ MD Child Psychiatrist Only (Longest Wait Time)	☐ MD Only (Child Psych or Dev/Beh Specialist)	☐ Any Prescribing Clinician (Shortest Wait Time)

If you would like a specific clinician, please write that clinician's name here: _____

If individual therapy is requested, please select the preferred provider(s). More than one may be selected, requests not guaranteed.

☐ PhD Psychologist (Cash Only)	☐ Fully Licensed Therapist on Insurance Panel	☐ Masters- Level Therapist (Cash Only)
☐ Supervised Therapist (Low Cash-Only Cost)		

If you would like a specific clinician, please write that clinician's name here:_____

Please fax completed referral form to (423) 464-7631

We will notify you via fax regarding the patient's appointment determination within 2 weeks from the time received in our office. Please notify the patient of the appointment date and time. If the patient you are referring to us is in immediate danger or harming themselves or anyone else, please refer them to the nearest emergency room or contact 911.**DO NOT** refer to us, we are **NOT** a crisis center.

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