Harford Belair Community Mental Health Center, Inc.

Outpatient Services Referral Form

(Please complete all information requested. Submission does not guarantee access to services.)

Patient Information: **Date of Referral:__________________**

Name:______________________________________ DOB: ____

Social Security Number:_________________________ Phone Number: _________________________________

Address: ____

Insurance (Medical Assistance, Medicare, and Grey Zone accepted only): _________________________________

We do not accept Medicare HMO Plans

Referral Source:

Name:_____________________________________ Phone: _____________________________________

Agency: ___________________________________

If referral is from Inpatient Psychiatric Unit, please include copy of records (admission note & medication list)

Clinical Information:

Diagnosis: ____

Current Symptoms:

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Current Medications:

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Legal Involvement (Probation, Parole, or Conditional Release. Copies of orders must be included):

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Please fax completed referral form Attention: Intake Department to 410-426-5143. A staff member will call to obtain any additional information needed and review eligibility. Please call 410-426-5650 with any questions.