



CONNECTICUTRENAISSANCE

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BOARD PRESIDENT
ALECIA ANDREWS

CHIEF EXECUTIVE OFFICER
KATHLEEN DESCHENES

Outpatient Behavioral Health Clinic Referral Form

CLIENT INFORMATION

Name: _____ DOB: _____ Gender: _____

Telephone: _____ - _____ - _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code _____ SSN: ____ - ____ - ____

Primary Language Spoken by Client: _____

Secondary Language Spoken by Client: _____

Parent/Guardian/Conservator (if applicable): _____

Relationship to client: _____

Telephone: _____ - _____ - _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code _____

Is the client and/or Parent/Guardian/Conservator aware of the referral? Yes No

Has the client and/or Parent/Guardian/Conservator signed a Release of Information? Yes No

Insurance Information

Insurance Provider: _____
Policy Number: _____ Group Number: _____
Primary Insured's Name: _____
Relationship to Patient: _____
Contact Information for Insurance Provider: _____

REFERRAL SOURCE

Name: _____ **Date of Referral:** _____
Agency/Organization: _____
Address: _____
City: _____ **State:** _____ **Zip Code** _____
Telephone: _____ - _____ - _____ **Email:** _____

Reason for Referral (Please check all that apply)

Mental Health Substance Use Co-occurring Disorders Gambling Disorders

Services Requested (Please check all that apply)

Group Therapy Individual Therapy Family Therapy Medication Management
 Medication-Assisted Treatment (MAT) Evaluation Only (Integrated Assessment)

ADDITIONAL INFORMATION

Please Provide Us with A Brief Reason For Your Referral. Include any relevant details such as patient history, current medications, specific concerns, etc.)

If a Release of Information has been signed for us to receive any of this information, please attach it to this referral along with any relevant medical records you can share at this time.