Seminole Tribe of Florida Center for Behavioral Health (CBH)
3006 Josie Billie Avenue
Hollywood, Fl. 33024
Phone: (954) 964-6338 Fax: (954) 967-5182

ELECTRONIC REFERRAL FORM

Date of Referral _____ **Referring Reservation** _____

Name of person referring/Contact Information _____

Referring Department _____

Patient Information

Patient Name		Male ☐ Female ☐		Date of Birth	
Tribal ID				Clan	
Address		City		Zip Code	
Home Phone		Cell Phone			
Language spoken in home		Reservation			

1. **Referral question or problem** (e.g. substance abuse, mental health)

2. **How long has this behavior been a concern?** _____

3. **Previous interventions that have been tried. What worked and did not work?** (e/g treatment program, medications, counseling).

4. **Please list special types of therapies used in the past**

5. **Please explain if there are any medical conditions or concerns present**

6. **Please explain the client's social/ emotional status** (e.g. isolating, depressed)

7. **Additional concerns or general information.**

8. Type of service being recommended.

_____

Office use only:

Assigned to _____ **Date** _____

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Referral Response/Action Taken

TO: _____ FROM: _____

Sent Via: ☐ Fax ☐ Mail ☐ In Person ☐ Other _____

Comments: _____

Signature: _____ Date: _____

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