



Coplin Health Systems

New Patient Behavioral Health Referral Form

Date: _____

Name: _____

First

MI

Last

Preferred Name

Preferred Pronouns (please circle) he/him/his she/her/hers they/their/theirs other _____

Address: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Age: _____ SSN: _____

Parent/Guardian Name: _____

Relationship to Patient: _____

Reason for Referral: _____

Treatment: (please circle) Behavioral Health Therapy Substance Use Disorder Psychological Testing

History of drugs or alcohol? _____ Currently prescribed Methadone or Suboxone? _____

Referral Source: _____ Contact # _____

Insurance Information

Insurance Company: _____

Phone: _____

Employer's Name: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____

Phone: _____

Relationship to Patient: Self _____ Spouse _____ Child _____ Other: _____

DOB: _____ SSN: _____

Address: _____

Is there a Secondary insurance? Yes _____ No _____