INTEGRATED SERVICES
for behavioral health

HEALTHY PEOPLE.
STRONG COMMUNITIES.

Name:_____ DOB:_____SSN:_____

Parent/Guardian Name (if youth): _____

Address:_____Phone: _____

Alternate Phone Number: _____School (if youth): _____

Requested Service:

- ☐ Behavioral Medicine
- ☐ CANS Assessment
- ☐ Counseling
- ☐ Home-Based
- ☐ Housing
- ☐ I-FAST
- ☐ Maryhill Youth & Family Center
- ☐ Medication Assisted Treatment
- ☐ OhioRISE
- ☐ School-Based
- ☐ Substance Use Disorder
- ☐ Other: _____

Urgency:

- ☐ Suicidal/Homicidal
- ☐ Pregnant/Substance addicted
- ☐ Recent inpatient stay for behavioral health
- ☐ Recent ER visit for behavioral health
- ☐ Homeless

Payer Information

- ☐ Medicaid
- ☐ Medicare
- ☐ Commercial Insurance
- ☐ Other:_____

Referral Source Information

Name & Agency of Referrer: _____

Would you like to be notified that an appointment was scheduled? ☐ Yes ☐ No
If yes, how would you like to be contacted?

- ☐ Email: _____
- ☐ Fax: _____
- ☐ Telephone: _____

Reason for Referral: _____

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