OUT OF REGION REFERRAL FORM

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REFERRAL PROCESS

1. Referral source completes the referral form and locates receiving Provider for needed service.
2. Referral source sends referral to Region 1 Network Manager or Region 1 Emergency System Coordinator. Region (contact information is listed above.)
3. Region 1 staff will negotiate payment arrangement within 48 hours Monday thru Friday.
4. In the event a receiving provider cannot be identified, Region 1 staff will help assist referral source with locating other potential Providers and / or Payer sources, consultation with the referral source, and collateral contacts with consent.
5. As part of the referral process, a crisis relapse plan will need to be developed on case-by-case bases, with the consumer and the referring provider. Region 1 staff will review crisis relapse plan prior to admission to ensure consumer safety.
6. Region 1 staff will approve the referred person for services, if the provider deems the person meets clinical and financial eligibility criteria at the time of referral. All Region 1 staff will notify referral source and receiving facility of decision.
7. It is the responsibility of the referring clinician to make any and all referrals for all levels of so service. This could include after care placement after being in an emergency service.

CONSUMER INFORMATION

Consumer Name: Date of Birth: Gender: **Select**

Address: Phone Number:

Insurance Type: **Select** *if yes insurance provider

Income: **Select** * if yes income source: to include social security income

REFERRING SOURCE INFORMATION

Provider Name: Address:

Phone: Fax: Email

Service(s) Requested:

Current Services Provided:

Level of Care Requested: Region 1 Network Providers contacted:

Mental Health Board Commitment: Hearing Date:

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Additional information (why this service is requested, diagnosis, and previous treatments)

RECEIVING FACILITY INFORMATION

Facility Name: Address:

Phone: Fax: Email

Admission Contact Name: Phone if different from above:

Estimated Admit Date: Estimated Length of Stay:

REGION 1 USE ONLY

Date Received from Referring Source: Received By:

Date Receiving Facility Contacted: Date Staffed:

Referral Status: **Select** * if no reason:

Billing Contact Name: Phone: Email

LOA Signer Name: Title: Email:

Service: Admission Date: LOS: Rate:

LOA Created and Sent: LOA Returned and Saved:

Plan for One, if Required: **Select** PFO sent to DBH:

DBH Response Date: DBH Decision: **Select**

Additional information as necessary, to include additional services required: