Client's Name:
DOB:
Medical Record #:
Location:

☐ 2640 Forest Hill Blvd.
West Palm Beach, FL 33406
Phone: (561) 616-8411
Fax: (561) 616-8412

☐ 15818 SW Warfield Blvd.
P.O. Box 458
Indiantown, FL 34956
Phone: (772) 597-0411
Fax: (772) 597-0412

☐ 304 NW 5th St., Plaza 300
Okeechobee, FL 34972
Phone: (863) 357-8268
Fax: (863) 357-8269

☐ 726 20th St
Vero Beach, FL 32960
Phone: (772) 257-5264
Fax: (772) 257-5265

☐ 518 SW Prima Vista Blvd.
Port St. Lucie, FL 34983
Phone: (772) 873-8811
Fax: (772) 873-8800

Information & Referral: 1-888-97Legacy (1-888-975-3422) **Email:** admissions@legacybhc.com **Website:** www.legacybhc.com

REFERRAL FORM

Referral Source Information:

Date Of Referral:_____ Referral Source:_____ If Other, Specify:_____
Client Referred By:_____ Was the Client Referred by the School?:_____
Phone:_____ Fax:_____ E-Mail:_____

Client Information:

Name:_____ Social Security #:_____ Date of Birth:_____
Gender:_____ Primary Language:_____ Race:_____
Ethnicity:_____ Marital Status:_____ Living Arrangements:_____
Phone:_____ Alternate Phone #: _____ Contact Name:_____
Address: _____ City:_____ State:_____
Zip:_____ E-Mail: _____ Do you have a living will?:_____
School: _____ If Other, Specify:_____ School's Phone #:_____

Parent / Guardian Information:

Guardian's Name:_____ Relationship:_____ Primary Language:_____
Does Guardian Have Legal Documentation? _____ Phone:_____
Alternate Phone #:_____ E-Mail:_____ Address:_____
City:_____ State:_____ Zip:_____

Guardian's Name:_____ Relationship:_____ Primary Language:_____
Does Guardian Have Legal Documentation?_____ Phone:_____
Alternate Phone #_____ E-Mail:_____ Address:_____
City:_____ State:_____Zip:_____

Services Requested:

1. ☐ Individual/Family Therapy
2. ☐ TBOS
3. ☐ TCM
4. ☐ Group Therapy
5. ☐ Psychological Testing
6. ☐ Psychiatric Evaluation
7. ☐ Medication Management

Note: Please attach all assessments and background information available. This is important for a fast opening of your case

Please Provide in Detail the Reason for Referral:

Client Financial Information:

Medicaid Number: Member Number:
Funding Source: Eligibility Checked By: