"Serving Today's Diverse Generation"
LEGACY BEHAVIORAL HEALTH CENTER, INC.

☐ 2640 Forest Hill Blvd.
West Palm Beach, FL 33406
561-616-8411; 561-616-8412

☐ 15818 SW Warfield Blvd.
P.O. Box 458
Indiantown, FL 34956
772-597-0411; 772-597-0412

☐ 755 27th Avenue SW
Suites 9 & 10
Vero Beach, FL 32960
772-257-5264;772-257-5265

☐ 304 NW 5th St. Plaza 300
Okeechobee, FL 34972
863-357-8268; 863-357-8269

☐ 2632 SW Pt. St. Lucie Blvd.
Port St. Lucie , FL 34953
772-873-8811;772-873-8800

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

REFERRAL FORM

Referral Source Information

Date of Referral: _____

Agency Name: _____

Recipient Referred by: _____

Phone: _____

Fax: _____

Recipient Demographics

Name: _____

Social Security #: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____

City: _____ State: Zip Code: _____

Phone: _____ Alternate Phone: _____

Email: _____

Parent/Legal Guardian Information

Guardian's Name: _____ Does Guardian have Legal Documentation: ☐ YES ☐ NO

Address: _____ Phone: _____

Alternate Phone: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Recipient's School: _____ School Phone: _____

Language(s) spoken by Recipient: _____ By Parents: _____

Living Arrangements: ☐ With Family ☐ Therapeutic Foster Home ☐ Home ☐ Shelter ☐ Foster Care

Services Requested

In Office

- ☐ Psychiatric Evaluation
- ☐ Medication Management
- ☐ Psychological Testing
- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Aged/Disabled Adult Eldery/ Medicaid Waiver Program
- ☐ Substance Abuse Services
  - □ Outpatient

In Home

- ☐ Therapeutic Behavioral On-Site (TBOS)
- ☐ TBOS/ Therapeutic Support Service (TBOS/TSS)
- ☐ Targeted Case 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:

_____

_____

_____

Recipient's Financial Information

Medicaid Number: _____

Funding Source: _____

Member Number: _____

Bill to: _____

Eligibility Ck By: _____

Office Use Only

Date Received: _____ Time: _____

Received Via: ☐ Fax ☐ Walk-In ☐ Phone Other: ___

Assigned Screener: _____

Record No. Assigned: _____