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

☐ 701 NW Federal Hwy, suite 101
Stuart, Fl 34994
Phone: ((772)497-0049
Fax: (772) 232-6307

☐ 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

☐1924-1926 Dairy Rd
West Melbourne, FL 32904
Phone: (321)256-8000
Fax:(321) 327-2747

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:________________________
How did you find out about us? ☐ Website ☐ Radio ☐ Magazines ☐ Word of Mouth ☐ Radio ☐ Referral

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 Guardianship Documentation? __________________ Phone:__________________
Alternate Phone #:____________________ E-Mail:_______________________ Address:_________________
City:________________________________ State:________________________ Zip:____________________

Guardian's Name:____________________ Relationship:____________________ Primary Language:_________
Does Guardian Have Legal Guardianship 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: Funding Source:
Eligibility Checked By: