BellVue Health PLLC

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CLIENT & REFERRAL FORMS

Service Referral Form

Request a service screening. A referral does not establish eligibility or guarantee admission. This form is not monitored for emergencies. For immediate danger, call 911.

Person being referred

Full name

Date of birth

Phone

Email (optional)

Address / city / county

Medicaid / insurance plan

Member ID (secure submission only)

Referral details

Service requested

Referral date

Reason for referral / current needs (brief summary)

Referring person / agency

Phone / email

Permission to contact the person about this referral

☐ Obtained ☐ Not yet obtained ☐ Self-referral

Guardian / representative name and phone, if applicable

Submit records only through an approved secure process. Do not attach psychotherapy notes or specially protected substance use records to this form.

Referrer signature

Date (MM/DD/YYYY)

Please complete all applicable fields. Keep a copy for your records.