UBHS
United Behavioral Health Solutions

Psychiatric Services Referral

Please fax this referral to 770-212-2203 or email this form to referrals@ubhsinc.com

Feel free to attach any information on past behavioral health treatment, CCFA, IEP or other information. Alternatively, please fill out our patient intake form if no other information is available.

Referring Facility: _____ Contact: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Gender Identification: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone: _____

Current Issues or Challenges:

_____

Pharmacy: _____

Guardian Name: _____ Guardian Phone: _____

Is this child in DFCS custody? ☐Y ☐N

Insurance Information

Primary Insurance Name: _____

Member Number/ID: _____ Group Number: _____

Primary Insurance Phone Number: _____

Secondary Insurance Name: _____

Member Number/ID: _____ Group Number: _____

Insurance Member/Provider Services #: _____

☐This is a Self-Pay patient

Please attach a copy of the insurance card (front and back) and ID. Thanks!