Referral to Clatsop Behavioral Healthcare – Outpatient Services

Corporate Office/Mail: 65 N. Highway 101 Suite 204 Warrenton, OR 97146
Fax: (503) 861-2043 • Email: CBHReferrals@clatsopbh.org

Thank you for choosing Clatsop Behavioral Healthcare. In order for our agency to process your referral, we need the following information.

Provider Information	
Facility Name:	
Facility Address:	
Facility Phone #:	**Facility Fax #:**
PCP Name:	

Patient Information	
Patient Legal Name:	
Date of Birth:	
Parent/Guardian (if applicable):	
Mailing Address:	
Home Phone / Cell#:	**Ok to leave message? ☐ Yes ☐ No**
Is an interpreter required? ☐ Yes ☐ No	**If yes, language / dialect:**
Insurance:	

Reason for referral? Please be as specific as possible (i.e., Psychiatric Assessment, Medication Management, Mental Health Services, Drug and Alcohol Services, COVID-19)

What outcomes, if known, are you expecting from this referral?

Please attach the following records which will aid our staff in making a determination for eligibility:

- ✓ **Face sheet / Demographic Information**
- ✓ **Release of Information**
- ✓ **List of prescribed medications**
- ✓ **Pertinent recent chart notes / Discharge Summary**
- ✓ **Any other pertinent medical information**

If patient has a severe and persistent mental illness(es), and Priority Care is requested, please attach past (3) medical visit notes