FACILITY REFERRAL FORM

Gateway Children's Mental Health Services

Phone: (864) 406-6041
Fax: (864) 406-6042

Website: gatewaychildrens.com

MEDICAID ACCEPTED!

Email To: referrals@gatewaychildrens.com | Fax To: (864) 406-6042

✓Referring Doctor/Agency/Facility: _____Fax: (_____)_____-_____

✓Contact Name:_____Phone:_____Email:_____

4 REFERRAL LOCATIONS (SELECT ONE)**:** ☐ **Greenville** ☐ **Mauldin** ☐ **Anderson** ☐ **Spartanburg**

Date: _____ Child's Name: _____Age:_____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Telephone: Home: _____ Mobile: _____ Gender: ☐ Male ☐ Female

Social Security Number:_____-_____-_____ Parent/Guardian Name:_____

[Medicaid Plans & Self-Pay Accepted Only

Medicaid Plan: ☐State Medicaid ☐First Choice ☐Molina ☐Blue Choice ☐Absolute Total Care ☐Advicare ☐Wellcare

Member ID/Policy Number:_____

☐Self-Pay – we will contact parent(s) to discuss payment arrangements.

☐ Non-English speaking -- ****Client's responsibility to provide own interpreter for services to be rendered.**

Reason For Referral

Referral is for: ☐ Counseling: ☐ Behavioral Therapy ☐ Play Therapy ☐ Trauma/Crisis Therapy ☐ CALOCUS

☐ Professional Consultation

Additional Comments:

_____

Please provide the following patient information below:

- Primary Diagnosis (past or present): _____ Dx Code:_____
- Secondary Diagnosis (past or present): _____ Dx Code:_____
- Did this child have a mental health assessment done in the last 6 months? ☐ Yes ☐ No
    - If yes, who did the assessment?_____
- Is this child in the DSS foster care system? ☐ Yes ☐ No

NOTE: If services are court ordered or for facility needing a diagnostic assignment (please complete section below):

- List recommended PRS units/day for this child:_____
- List recommended Behavior Modification units/day for this child: _____
- List recommended FS units/day for this child: