NEW HORIZONS
Behavioral Health Center

Client Information **Referral Form for Mental Health Services**

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❒ Male ❒ Female	School & Grade:	
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		
Name of Bayou Health Provider:	Insurance ID #	

Parent or Legal Guardian Information if different than Client:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name:	Mailing Address:
Phone Number:	Email address:
How did you hear about New Horizons Behavioral Health Center?	

Child/Adult Mental Health Information:

Current medication & dosage
Prescribing Physician name & Phone

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

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Fax all referrals to (225) 953-8175. Clients will be contacted within 2-3 business days to schedule an initial assessment. Thank you for your referrals.

For office use only: Date referral received_____ Assessment scheduled_____ @ _____ AM/PM

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