Referral Form

PATIENT INFORMATION	
Patient's Full Name	**DOB**
Phone #	**Alt Phone #**

What type of primary insurance does the patient have? ☐ Medicare ☐ Commercial ☐ Medicaid ☐ None

Does the patient have secondary insurance? ***(if yes, specify:)*** _____

Referring Facility: _____

Relationship to patient: _____

REASON FOR REFERRAL TO ASTRA BEHAVIORAL HEALTH

_____

_____

Current Medications: _____

☐ **Therapy Services** ☐ **School Based Therapy** ☐ **Day Treatment Program** ☐ **Psychiatry *(Medication Management)***

☐ **Medication-Assisted Treatment *(Addiction Treatment)*** ☐ **Spravato** ☐ **TMS *(Transcranial Magnetic Stimulation)***

☐ **SUD Adolescent IOP** ☐ **Targeted Case Management**

If you selected School Based Therapy or Day Treatment Program, please choose one of our program locations below:

☐ **Hardinsburg** ☐ **Bardstown/Nelson County** ☐ **Shepherdsville**

How did you hear about us? _____

Please email referrals to intake@astrabh.com or fax to 270-900-4167
Patients can submit the New Patient Registration online and will be contacted to schedule