ASTRA BEHAVIORAL HEALTH, LLC

Targeted Case Management Referral

PATIENT INFORMATION	
Patient Name:	DOB:
Guardian Name (if minor):	Phone Number:
SSN:	Address:
Email Address:	Is Patient Aware of Referral?
INSURANCE INFORMATION	
Primary Insurance:	Policy Number:
Secondary Insurance:	Policy Number:
REFERRAL SOURCE INFORMATION	
Referring Provider:	Provider Credentials:
Email Address:	Phone Number:
ELIGIBILITY INFORMATION	
Mental Health Diagnoses:	Mental health services patient is currently receiving:
Any co-occurring medical problems:	Any previous psychiatric hospitalizations:

Part of the referral process for TCM services is to complete a determination checklist

- For Children/Adolescents you will use the SED Checklist found here: https://dbhdid.ky.gov/documents/cmhc/crd/ChecklistSED.pdf
- For Adults you will use the SMI Checklist found here: https://dbhdid.ky.gov/documents/cmhc/crd/ChecklistSMI.pdf

Please include the checklist and any relevant medical record listing the patient's diagnosis when submitting this referral form.

You can submit the referral information by fax to 502-349-3173 or

by email to rbowman@astrabh.com / elewis@astrabh.com