ALASKA BEHAVIORAL HEALTH

4020 Folker St ● Anchorage, Alaska 99508 ● 907-563-1000 ● (Fax) 907-375-3115 ● website: www.alaskabehavioralhealth.org

Provider Referral Form

Before submitting a referral, please confirm that the client is interested in receiving services, and note the following:

- We do not provide ongoing clinical services based solely upon court order or probation or parole office request. All services must be medically necessary as determined by an AKBH clinician or medical provider and consented to by the client/patient and/or guardian as part of an individualized treatment plan.
- We do not provide evaluations for parental fitness, child custody, fitness for duty, disability, worker's compensation, or other forensic purposes.
- We do not provide sex offender treatment.

Please choose the best option below: (This will help us route your request to the best location; all options will be considered to best serve the client.)

☐ Adult, Interior & Northern Alaska (including Fairbanks)
☐ Child, Interior & Northern Alaska (including Fairbanks)
☐ Adult, Southcentral (including Anchorage), Southwest or Southeast
☐ Child, Southcentral (including Anchorage), Southwest or Southeast
☐ Steven A. Cohen Military Family clinic

Please choose primary service requested: (Treatment option will be discussed during initial evaluation.)

☐ Outpatient Therapy (Individual, Group, Family)
☐ Outpatient Psychiatric (Medical)
☐ Adult Mental Health Residential Treatment
☐ Adult Partial Hospitalization (PHP)**
☐ Child (9-17) Partial Hospitalization (PHP)**

****AKBH Partial Hospitalization Program located in Anchorage (travel and lodging is potentially covered by your insurance please inquire with them prior to referring from outside Anchorage area) ****

Today's Date

Referred by: ______________________ **Title:** ________________ **Telephone:** ____________________

Facility/Office Name____

Client Information

Name: _______________________________________ **Date of Birth** ______________ **SS#**_______________

Address: ____

Phone: __________________________ **Insurance:** ____

Guardian's Name & Phone # (if applicable) ____

Previous/Current Diagnosis if known____

Reason for referral: Anxiety, Depression, PTSD, ADHD or other mental health or substance use related condition____

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Please FAX completed form and medical records to **907-375-3115**