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|  **REFERRAL FORM FOR BEHAVIORAL HEALTH SERVICES** |

**Date of referral:**   **Individuals Name:**

**Phone Number:** **DOB:**

**Address:**

**Insurance Plan: Insurance ID Number:**

|  |  |
| --- | --- |
| **☐ Substance Use Disorder** | **☐ Mental Health** |

* **Grandview Office**

106 N. Elm St

P.O. Box 748

Grandview, WA. 98930

Ph. 509.402.9090 Fax. 1.866.974.8679

* **Kennewick Office**

333 W. Canal Dr.

Kennewick, WA.

Ph . 509.581.0303 Fax. 1.866.974.8679

**Please describe circumstances for referral:**

**Referent Name:**       **Phone #:**  **Email/Fax:**