BMWIT Patient Referral (External)

Phone: (971) 342-0117
Clinic ext. 1
Scheduling ext. 3
Billing Department ext. 4

Submission must be confidential using one of the following ways:
Email: bmwitmentalhealth2022@gmail.com
Fax: (503) 296-2937

This fillable form is to be used to refer clients to BMWIT for mental health and wellness services. Please complete all required sections electronically.

External Referral Facility/Organization:			
Name		**Referral Date**	
Facility/Organization Address	**City**	**State/Zip**	
Phone	**Ext.**	**Fax**	**Email**
Referral Approved by (Name):			
Initials:			

Recommended Services (Check All That Apply)

Client Focus

RACE/ETHNICITY

Are you Hispanic or Latino(a)
☐ Yes ☐ No

Please select which best identifies the client:

☐ **Black or African**
☐ **Native American (Indigenous)**
☐ **African**
☐ **White or Caucasian**
☐ **Other:** ___________

Vital Signs are required for each visit.

Additional Comments:

Relationship Counseling
☐ Family
☐ Children
☐ Teens
☐ Spouse
☐ Couples

Oppositional Defiance (ODD)
☐ Parenting
☐ Peer Relationships
☐ Relationship Issues
☐ Self Esteem

Behavior Issues
☐ Toddler/Child
☐ Pre-Teen
☐ Young Adult
☐ Adult
☐ Anger Management
☐ Chronic Impulsivity
☐ Coping Skills
☐ Emotional Disturbance
☐ Life Coaching
☐ Family Conflict
☐ Grief
☐ Self-Harming

Spirituality
☐ **Yes**
☐ **No**
☐ **Other**

Mental Health Counseling Specialties
☐ Addictions
☐ Anxiety
☐ Depression
☐ EMDR
☐ Trauma
☐ PTSD

Concerns
☐ ADHD
☐ Mood Disorders
☐ Psychosis
☐ Substance Abuse
☐ Suicidal Ideation
☐ Chronic Impulsivity

Treatment Approach/Types of Therapy
☐ Cognitive Behavioral (CBT)
☐ EMDR
☐ Family Systems
☐ Interpersonal
☐ Individual
☐ Group
☐ Massage
☐ Therapeutic Martial Arts
☐ Yoga

☐ **Psychiatric Nurse Practitioner**
Medication Management
Other:

Modalities Available
Individuals
Family
Group
Spouse
Couples
Children (beginning at age 6)

Type of Service Appointment
☐ Intake
☐ Assessment
☐ Mental Health
☐ Medical
☐ Auto
☐ Works Compensation
☐ Medication
☐ Sports Physical
☐ Other

☐ **Family Nurse Practitioner (FNP)**
Primary Care Provider
Wellness Services
Physical Assessments
Medication Management
Other:

Client Information			
First Name	**Last Name**	**M.I.**	**DOB**
School	**Grade**	**Age**	**Gender**
			☐M ☐F or Other ☐
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
Email Address			

Complete as much information as possible **Insurance Name** Primary: Secondary: Tertiary: (3 Party payor) **Phone Number:** Primary Secondary Tertiary	**Insurance ID:** Primary Secondary Tertiary **Group #:** Primary Secondary Tertiary **Policy#:** Primary Secondary Tertiary
Copy of your State ID and Insurance card is required Insured Name:	Primary Insured name: DOB: SSN: Phone number: Secondary Insurance name: DOB: SSN: Phone number: **Tertiary** Insurance name: DOB: SSN: Phone Number: **If Guarantor please check here** ☐

PROCESS

- Allow 48 – 72 hours to respond to the referral or to notify the patient.
- If communication is needed between the provider or coordinator, please send an authorization for the release of information signed by the client/patient and the provider or coordinator.
- If applicable, please include the release of information (ROI) request form with this referral.