Brattleboro Retreat
COMPREHENSIVE MENTAL HEALTH SERVICES SINCE 1834

EXTERNAL PROVIDER REFERRAL FORM-Outpatient Clinic

(Clinical notes to be provided with this form as referenced at the bottom; fax (802) 258-3788 or email Outpatient@brattlebororetreat.org)

PLEASE CHOOSE ONLY ONE PRIMARY SERVICE REQUESTED

☐ Outpatient Psychiatry (Outpatient Psychotherapy may be deemed a requirement)

☐ Outpatient Psychotherapy ☐ Psychological Testing

☐ Outpatient Group Psychotherapy

CLIENT INFORMATION

Legal Last Name: _____ Legal First Name: _____ DOB: _____

Mailing Address: _____

Street Address (if different): _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____ Preferred Method of Contact: _____

INSURANCE INFORMATION

****If insurance is BCBS Out of State (not BCBSVT) or Anthem, a referral from the PCP will be required****

Primary Insurance: _____

Primary Insured Party Name: _____ DOB: _____

Relationship to Patient: _____ Policy #: _____ Group #: _____

Effective Date: _____ Expiration Date: _____

Secondary Insurance: _____

Primary Insured Party Name: _____ DOB: _____

Relationship to Patient: _____ Policy #: _____ Group #: _____

Effective Date: _____ Expiration Date: _____

PRESENTING PROBLEM(S)

Previous/Current Diagnosis

_____
_____
_____
_____

Reason for Referral

_____
_____
_____
_____
_____
_____

REFERRING PROVIDER

Referred by: _____ Practice Name: _____

Telephone #: _____ Submission Date: _____

Upon receipt of completed referral and clinical notes from recent visits, the next steps are as follows:

Patient responsibility:

- Complete and return the program packet (assistance is available if requested)
- Attach insurance card images

Brattleboro Retreat steps:

- Financial eligibility will be reviewed within 48 business hours
- Clinical review to determine program eligibility
- Patient will be contacted with next steps