Promoting wellness through behavioral health care services

ACMHS Anchorage Community Mental Health Services

FCMHS Fairbanks Community Mental Health Services

4020 Folker Street • Anchorage, Alaska 99508 • 907-563-1000 • (Fax) 907-563-2045 • e-mail: info@acmhs.com • website: www.acmhs.com

Anchorage Community Mental Health Services, Inc.
Adult Client Referral Form

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: (ie Anxiety, Depression, PTSD, Mood Disorders, etc.)

_____

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☐ Check here if you are an outpatient provider referring for medication management only. This may be considered for clients age 18+ who are continuing therapy elsewhere or have been receiving treatment from another psychiatric medical provider and determined not to require ongoing psychotherapy or case management services through ACMHS. Please provide medical records including diagnoses and medication list, if applicable, for the past 6 months and your contact number with this referral form.

Please FAX completed form and medical records to **907-563-2045**.

Internal Use Only		
Scheduled for Intake: (date)_____	**Attempted to Contact: (dates)_____, _____, ____**	**Closed: (date) _____**