



4045 Lake Otis Parkway • Anchorage, Alaska 99508 • 907-561-0954 • (Fax) 907-561-7093 • e-mail: info@acmhs.com • website: www.acmhs.com

**Anchorage Community Mental Health Services, Inc.
Child 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.)

If there is specific program you are interested in, please indicate here:

Little Tykes Military Child Family Program Parenting with Love & Limits

Please FAX completed form and medical records to **907-561-7093**.

Internal Use Only		
Scheduled: (date) _____	Attempted to Contact: (dates) _____, _____, _____	Closed: (date) _____