



1423 Peger Road • Fairbanks, AK 99709 • 907-371-1300 • (Fax) 907-371-1387 • e-mail: info@fcmhs.org • website: www.fcmhs.org

**Fairbanks 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.)

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 FCMHS. 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 **907-371-1387**.

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

