REFERRAL FORM

BEHAVIORAL CARE SOLUTIONS, LLC.

Geriatric Psychiatric Services, PLLC and Total Care Solutions SC

Main Office - 39465 W. 14 Mile Rd, Novi, Michigan
48377 Toll Free: 877-906-9699 Fax: 888-483-0118
Illinois Office - 1 Westbrook Corporate Center, Suite 300, Westchester, IL 60154-5709 Local 708-375-3075

Email info@bcsgps.com or BCSScheduling@bcsgps.com

Facility: _____

Date: _____

Please fax completed form and corresponding face sheets to 888-483-0118 (Main Office) or email to bcsscheduling@bcsgps.com

The following residents are being referred to you for psychiatric services with follow up treatment as needed pursuant to the order of the attending physician (please check "x" all that apply). Further, the resident or the responsible party, as the case may be, is aware of and has authorized these services and the assignment of benefits. A face sheet for each named resident is attached to this Evaluation Request Form. By signing below, the undersigned acknowledges the accuracy of the above statements.

_____ _____

Signature of Authorized Facility Representative **Print Name and Position**

Please Indicate Referral Reason by checking ("x") all applicable corresponding numbers - (1) Mental Status (2) Behavioral Issues; (3) Medication Management; (4) Resistance or Refusal of Care; (5) Suicidal Ideation; and (6) Cognitive Evaluation. Please Provide Brief Explanation and any other referral reason in Comment Section.

Room #	Resident Name	Referral Reason (check all that apply) 1	2	3	4	5	6	Comments