FRESNO STATE
Behavioral Sciences Institute

REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to the BSI office, 559.278.0015. Include brief pertinent medical records, including diagnosis or supporting documentation that support the consultation. If you require additional assistance, please call 559.278.6779.

Date: _____ From: _____

No. of Pages: _____ Title: _____

To BSI Service: _____ Phone: _____

PATIENT INFORMATION

Name of Patient: _____

DOB: _____ Language: _____

Phone: _____ Cell Phone: _____

Name of Parent(s)/Guardian(s): _____

Address: _____

City: _____ Zip: _____

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

By providing the information requested and signing below, you agree that we may initiate treatment following assessment or consultation, in association with this assessment. We look forward to collaborating with you and your patient's treatment plan.

RFERRING PHYSICAN INFORMATION

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

PCP Name: _____ Phone: _____

Check if referring for:

❒Early Intensive Behavior Intervention (EIBI) - Autism Center @ Fresno State ❒Behavior Intervention Services (BIS) @ Fresno State
❒Early Intensive Behavior Intervention (EIBI) – Fresno State Autism Center @ Valley Children's Hospital

REFERRAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Date Requested: _____ #of Visits _____

❒Assessment Only ❒Assessment and Treatment ❒ Referral for Treatment

SIGNATURE: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminated any of the information contained herein.