Samaritan Counseling Center Hawaii

Referral Request for Outpatient Mental Health Services

Date of Referral: _____ **FOR SCCH USE: CLIENT ID** _____

Referring Agency Information (please print)

Referring Agency: _____

Referring Contact and Title: _____

Phone: _____ **Fax:** _____

Email: _____

Patient Information (please print)

Name of Patient Referred: _____

Phone: _____ **Date of Birth:** _____

Email: _____

Patient's Health Insurance and Subscriber ID: _____

Parent/Guardian Name and Phone: _____

Reason for Referral: _____

_____

Requested SCCH Service:

- ❑ Diagnostic Assessment
- ❑ Individual / Family Mental Health Counseling

Patient's Primary Medical Diagnosis: _____

Other Medical Diagnoses: _____

REFERRAL SIGNATURE_____ **DATE:** _____

CONSENT FOR INFORMATION RELEASE

I, _____ hereby give my permission to release information to and request information from the referring agency and Samaritan Counseling Center Hawaii for appointments and coordination of care.

PATIENT SIGNATURE_____ **DATE:** _____

Fax referral form to (808) 545-2852 or email info@samaritanhawaii.org

Celebrating Over 30 Years of Service

1020 South Beretania Street, Honolulu, HI 96814 • Phone: (808) 545-2740 • Fax: (808) 545-2852

www.samaritancounselingcenterhawaii.org • Email: info@samaritanhawaii.org

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