

**AMBULATORY PEDIATRIC MENTAL HEALTH  
REFERRAL FOR OUTPATIENT SERVICES**

Patient Name:  
Medical Record #:  
DOB:  
Social Worker  
Date:

\_\_\_\_\_ **Blue Choice #**

\_\_\_\_\_ **Preferred Care #**

\_\_\_\_\_ **Blue Choice Option #**

\_\_\_\_\_ **Preferred Care Option #**

\_\_\_\_\_ **Child Health Plus #**

\_\_\_\_\_ **Medicaid (No ref. needed)**

\_\_\_\_\_ **Commercial Insurance #**

\_\_\_\_\_ **BCBS (No ref. needed)**

\*Primary Provider

Agency to which referral is being made: Strong Behavioral Health  
Strong Family and Marriage Clinic  
Crestwood Children's Center  
Unity Health  
Genesee Behavioral Health  
Family Service of Rochester  
Rochester Mental Health  
North Greece Counseling Services  
Psychology Fellows  
Other

Phone #

R/O Diagnosis:

Parent/Guardian phone #:

Referral #:

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Date of Parent/Guardian notified:

phone/mail

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