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COMMUNTIY ACTION TEAM (CAT) REFERRAL FORM

DOB:	ame: Phone Number: Social Security #:	Phone Number: Social Security #: Insurance #: Primary Care Doctor:	
Secondary Insurance:	In		
Referral Source:			
Address:		·	
Reason for Referral: (Behaviors	and Events Necessitating Ment	ital Health or Substance Abuse Referral)	
Printed Name & Credentials: Parent Signature	is aware that referral to Meridian Beha	Date: Date: havioral Healthcare has taken place and gives permission	on for
or Meridian Use Only:			
Insurance Type:	lr	nsurance Number:	
• ·• • ·• ··		Effective Date:	
Expiration Date:		Hours Approved:	
Staff Accianade		Date Assigned:	
Referral accepted:			
☐ Emergent	□ Urgent	☐ Routine	
Reviewed By:			
Clinical Director's Signature & Cre	· · · · · · · · · · · · · · · · · · ·	Date:	
Clinical Director's Printed Name 8	k Credentials:		

 $\textbf{Email school referrals to:} \ \underline{\text{kimberly law@mbhci.org}} \ \text{and} \ \underline{\text{tylyn.stansel@suwannee.k12.fl.us}}$