Promoting wellness through behavioral health care services

ACMHS Anchorage Community Mental Health Services

FCMHS Fairbanks Community Mental Health Services

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Anchorage Community Mental Health Services, Inc.

Client Referral Form

Today's Date_____

Referred by: _____ Title:_____ Telephone_____

Facility/Office Name_____

Client Demographic Information

Name: _____ Date of Birth _____ SS#_____

Address: _____

Phone:_____

Insurance: _____

Guardian's Name (if applicable) _____

Previous/Current Diagnosis if known_____

Reason for Referral:

Adjustment Disorder___ Anxiety ___ Depression___

Mood/bipolar___ Personality Disorder___ Psychotic Disorder___

PTSD Post Traumatic Stress Disorder___ Relationship Issues___

Substance Use Disorder (Level 1 only)___ Tobacco Cessation___

Grief ___ Other _____