Reset Form

L|E|C|O|M
MEDICAL CENTER AND
BEHAVIORAL HEALTH PAVILION

EAC Referral Form

Phone: (814) 868-4031

Demographic Information

Name: _____ **Date of Birth:** _____ **Age:** _____

Sex Assigned at Birth: ☐Female ☐Male **Gender Identity:** _____

SSN: _____ **Primary Phone:** _____ **Alternate Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ **Policy Number:** _____

Secondary Insurance: _____ **Policy Number:** _____

POA/Legal Guardian Information

Name: _____ **Relationship:** _____

Primary Phone: _____ **Alternate Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name: _____ **Relationship:** _____

Primary Phone: _____ **Alternate Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Medical Information

PCP: _____ **PCP Phone:** _____ **Height:** _____ **Weight:** _____ **Diabetic:** ☐Yes ☐No

Allergies: _____

Dietary Restrictions: _____

Special Needs: _____

Referral Source Information

Name: _____ **Relationship to Client:** _____

Primary Phone: _____ **Agency:** _____

INTERNAL USE ONLY

ADM.REF

Authorization Number: _____ **Arrival Date:** _____

UR Approval: _____ **Date:** _____

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Current Services

Name: _____ **Agency:** _____

Primary Phone: _____ **Fax:** _____

Name: _____ **Agency:** _____

Primary Phone: _____ **Fax:** _____

Name: _____ **Agency:** _____

Primary Phone: _____ **Fax:** _____

Name: _____ **Agency:** _____

Primary Phone: _____ **Fax:** _____

Medication Information

Date of Last PRN: _____ **Medication Used:** _____ **Dosage:** _____

Daily Medications:

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

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DSM-5 Diagnosis

Psychiatrist Recommending EAC: _____ **Date of Evaluation:** _____ **Primary Diagnosis:** _____

Additional Diagnoses: _____

_____

Medical Diagnoses: _____

_____

Reason for Referral (symptoms, behaviors, etc)

Barriers to Treatment Progress

Please send completed referral form, copy of current psychiatric evaluation recommending EAC and 3 days of progress notes by email to lecomeac@mch1.org.
If you have any questions please call, (814) 868-7668.

ADM.REF