TGH BH HUB Referral

Referring Provider Name and Contact Information:

_____

Name and preferred contact information for the individual who should receive consult summaries and ongoing updates, if different from the referring provider:

_____

Patient Name: _____DOB:_____

Patient Social Security if available: _____

Behavioral health symptoms impacting functioning (psychiatry input requested for diagnostic clarification, treatment guidance, medication options, etc.):

_____

_____

Please check the service requested: (Check all that apply)

- ☐ **Care Coordination combined with consultation or evaluation**
- ☐ **Care Coordination only**
- ☐ **Consultation with a Psychiatrist (Doc to Doc consult)**
- ☐ **Asynchronous consultation support when appropriate**
- ☐ **Psychiatric Eval with family, followed by a consultation with the provider.**

Comments:

_____

Email to BehavioralHealthHub@tgh.org or fax 813-844-6905
The referral form can also be completed digitally. Click here.