Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

BCMH/HMG REFERRAL FORM

BCMH Program

*******Only a Referring Agency may submit this referral*******

Agency Contact Completing This Form

Agency	Date of Referral
Service Coordinator	Phone
Email	Fax

Reason for Referral

Child's Information

Needs to be contacted within: ☐ 2 Weeks ☐ 4 weeks ☐ Other

Child's First, MI, Last Name		Date of Birth
☐ Male ☐ Female	Early Tracking Number (HMG Referrals Only)	
Child's Address		
City	Zip	☐ Child Does NOT have health Insurance
☐ Current Insurance Provider:		
Member ID	Group #	Policy #

Parent's Information (*address if different from child)

Check Best Day Number to Call

Name of Parent/Guardian 1		☐ Home ☐ Cell
Address*		☐ Work
City	Zip Code	☐ Other
Name of Parent/Guardian 2		☐ Home ☐ Cell
Address*		☐ Work
City	Zip Code	☐ Other
Interpreter Needed? ☐ Yes ☐ No	Language	

Pertinent Medical History Related to Referral

☐ Hospital Discharge Summary Attached

For: ☐ PHN Assessment ☐ Follow-Up to Medical/Hospital Care ☐ Provide BCMH Program Info ☐ Other	
Diagnosis:	
☐ No Known Allergies	List Allergies
Special Problems: ☐ Family Mental Health Issues ☐ Saftey Issues ☐ Other	
Explanation:	

Physician Information (if known)

Primary Care Physician	Phone
Specialist	Phone
Specialist	Phone

Please FAX Referral Form and supporting documents to FCPH AT 614-525-6673 Attn: Toni Stichert or Kim Trainer or EMAIL to bcmh@franklincountyohio.gov