Community Health Connections
We take great care of you!

CHC Referral Form

Day Treatment Programs (Full Day/Half Day)
Phone: 978 878-8581 x7031
Email contact: CHCdaytreatment@chcfhc.org

Referring Organization: _____ Date Submitted: _____Time: _____

Name of Patient: _____ Phone and Email: _____

*Primary Care Physician (PCP): _____ PCP Phone: _____

How did you hear about us? _____

Payment type: _____ Commercial Insurance _____ Medicaid/Medicare _____ Private Pay

Insurance Company: _____Policy Number: _____Co-Pay $: _____

Medicaid Type: _____ Medicaid/Medicare ID # _____

Have you been admitted to a psychiatric hospital within the past 30 days? _____

Date of Discharge: _____ Name of Hospital: _____

Diagnosis: (If one provided) _____

Current Medications: _____

Please provide discharge documents prior to intake assessment along with a current list of medications you are currently prescribed.