Pueblo of Santa Ana
Health and Human Services
02 Dove Road, Santa Ana Pueblo, NM 87004
Office: 505-771-6765
SocialServicesDept@santaana-nsn.gov

BEHAVIORAL HEALTH REFERRAL FORM

(IF THE PERSON YOU ARE REFERRING IS IN IMMEDIATE DANGER CALL 911)

YOUR CONTACT INFORMATION

Name: _____ Date: _____

Address: _____

Phone #: _____

ORGANIZATION (IF ANY):

Program Name: _____

Other Agencies Involved: _____

WHO ARE YOU REFERRING?

Name: _____ DOB: _____

Parents/Caretakers Name (if applicable): _____

Address: _____

Phone#: _____ Email: _____

Court Case/Police Report # (if applicable) _____

REASON FOR REFERRAL:

(Someone from Behavioral Health will contact you for a follow up and more detailed information)

_____

_____

_____

_____

Does the client know of referral? Yes No

Would you like to remain anonymous? Yes No

Can we (HHS) identify ourselves? Yes No

Suicidal Ideation? Yes No

Official Use Only:

Date Received: _____ Time: _____ Initials: _____

Behavioral: ☐ Substance: ☐