**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 ☐

Are there concerns of suicide? Yes ☐ No ☐

**Official Use Only:**
Date Received: _____ Time: _____ Initials: _____
Behavioral: ☐ Substance: ☐