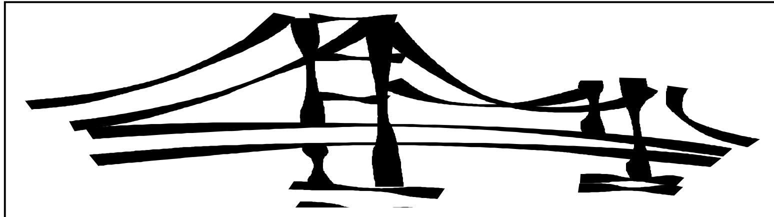

Bridges Behavioral Health
Phone 425 267 9111
Fax 425 374 3015

Referral Request & Authorization of Psychological Services

Name of Referred Person	Date of Referred	Referred Person's Phone Number
Address of Referred Person (Street, City, State)	**Zip Code**	**Alternate Phone Number of Referred**

Name of Person Making the Referral		Relationship to Referred
Address of Person Making Referral	**Home Phone Number**	**Alternate Phone Number**
Type of services required	☐ Individual ☐ Couple ☐ Family ☐ Addiction ☐ Assessment	

Please provide a brief description of the current problematic issues which provide the basis for this referral

Please provide an amount or percentage of the fees to be paid by responsible party		
The Referred	**Third Party Assistance (specify Ward, Ins. Etc.)**	**Please contact Referrer**

Signature of Person Making Referral   **Date**