



**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	<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Addiction <input type="checkbox"/> 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