# EXTERNAL PROVIDER REFERRAL REQUEST

Email to: referrals@azcfc.com or fax to 602-253-8340

**Referring Provider Information:**

**Provider Name:** **Referral Date:**

**Address:** **City** **State** **Zip**

**Provider Phone #** **Provider Fax#**

**Contact Person:** **Supervisor**

**Member/Client Information:**

**Name:** **DOB** **Member ID#**

**Insurance Plan:** **Insurance Phone#**

**Guardian Information:** **Guardian Phone if Different:**

**Address:** **City** **State** **Zip** **Telephone #**

**Diagnosis:**

**Medications:**

**Program/Service Requested:**

**Program/Service Requested:** ☐ DBT ☐ CBT ☐ Expressive Arts ☐ EMDR ☐ Anger Management

☐ CANDIS (Marijuana Ed/Treatment) ☐ Cognitive Restructuring (MRT/Forward Thinking)

☐ Sexual Abuse Recovery ☐ LGBTQ/Gender Transition Therapy ☐ General Mental Health

☐ Sexual Maladaptive Behavior (Adolescents) ☐ Sex Offender Treatment (Adult)

☐ Sexual Risk Assessment (Psychosexual) ☐ Biofeedback ☐ Teletherapy

☐ Other:

**Why does this person need this service?**

**AZCFC Use Only**

**Referral Accepted:** ☐ **Yes** ☐ **No** **Date:**

**Reason for Decline:**