**Single Service Referral**

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| Consumer Name: | DOB: |
| Referring Agency & Contact Info: | MHWIN ID: |
| Consumer/Guardian Contact Information: | Date Requested: |

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| Service(s) Requested & CPT Codes: |
| Briefly Explain rationale for Referral(s): |

An Authorization has been completed and approved through the following source:

* DWIHN General Authorization
* MI Health Link (required for all requested therapy/psychiatric services when an individual is enrolled in this program)
* GF Authorization
* Consumer is self-determined

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| Date Range of Authorization: |
| Treatment Plan Expiration: |
| BPS Expiration Date: |
| Axis I Diagnosis: |

**The following must be included with this referral: IPOS (including language regarding the service, Valid Authorization(s), and Prescriptions for services if requesting Speech or occupational therapy.**

**Please fax or email the referral request form to the sites below, making attention to the site supervisor.**