PATHWAYS BEHAVIORAL HEALTH, INC
440 Louisiana St. Suite 803
Houston, TX. 77002
Phone: *346.335.2936* Fax: *281.624.4946* Email: *contactus@pbhinc.org* *Website: www.pbhinc.org*

Mental and Behavioral Health Services Referral

Name:			Date of Birth:	Race/Ethnicity:	
Gender:	Male	Female	School & Grade:		
Services Requested:		Office-Based Outpatient		School/Home Based	
Contact Number:				Message ok? Yes	No
Address:					

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Disrespectfulness/Parent/Teachers	☐	☐	☐	☐	☐
Grieving Issues/Death	☐	☐	☐	☐	☐
Failing/ Declining Grades	☐	☐	☐	☐	☐
Abuse/Addictive Behaviors/Sexual Assault	☐	☐	☐	☐	☐
Conduct Behavioral	☐	☐	☐	☐	☐
Suicidal Thought/Behavioral	☐	☐	☐	☐	☐
Mental Health Issues	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Developmentally Delayed	☐	☐	☐	☐	☐
Lack of Family Support	☐	☐	☐	☐	☐
Divorce or Marital Issues	☐	☐	☐	☐	☐
Social Withdrawal	☐	☐	☐	☐	☐
Finance Issues	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Stressed/Anxiety/Panic Attacks	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Problem with the School	☐	☐	☐	☐	☐
Anger / temper tantrums	☐	☐	☐	☐	☐
Eating problems	☐	☐	☐	☐	☐
Bullying	☐	☐	☐	☐	☐
Oppositional Defiant to those in authority	☐	☐	☐	☐	☐
Attachment Disorder	☐	☐	☐	☐	☐
Other (explain)		☐	☐	☐	☐

Referred by: [Service provider's name, telephone, and fax number]

_____

_____

Signature: _____ Date: _____