

S.T.A.R. Referral Form



Date of Referral: _____ Referred by: Clinic Doctor Self Family/ Friend
Behavioral Health Provider Other

How did you hear about S.T.A.R.? _____

Member Information

Member Name: _____ Date of Birth: _____

AHCCCS ID#: _____ Diagnosis Code: _____ Title XIX Non-Title XIX

Physical Address: _____

Phone #: _____ Primary Language: _____

Relevant medical conditions or allergy risks: _____

Does member have any behaviors or needs that require additional attention from S.T.A.R. staff: _____

Is the members an immediate or imminent danger to self or others? Yes No

Cross System Involvement: DDD Probation DCS

Please list any chronic physical health issues the member is currently being seen for: _____

Doctor's Name: _____ Doctor's Phone #: _____

Guardian's Information (if applicable)

Guardian's Name: _____ Guardian's Relationship to member: _____

Guardian's Phone# (if different from above): _____ Best time to contact: _____

Assigned Clinic Information

Assigned Clinic Agency: _____

Case Manager Name: _____ Clinic Phone #: _____

Case Manager Email Address: _____

Areas of interest to the member:

- | | | |
|--|---|---|
| <input type="checkbox"/> Peer Support | <input type="checkbox"/> Recovery Focused Groups | <input type="checkbox"/> Discharge Care Coordination |
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Opioid Support Groups |
| <input type="checkbox"/> Independent Living Skills | <input type="checkbox"/> Job Skills | <input type="checkbox"/> Young Adult Program (Ages 18-25) |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Health, Wellness, and Exercise | <input type="checkbox"/> NTXIX Chronic Medical Services |

Location of interest to member:

- S.T.A.R. Central (Phoenix) S.T.A.R. East (Mesa) S.T.A.R. West (Avondale)