Referral to Behavioral Health

APIA
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
With Spirit and Strength

Send completed referral to: registration@apiai.org or Health Fax: 907-222-4279
Registration/Scheduling: 1-907-222-9764 or 1-844-375-2742 (toll free)
Hours of Operation: Monday - Friday, 8:00AM – 5:00PM

If individual is in crisis call 911, Public Safety, Village Public Safety Officer, 988 or Careline 1-877-266-4357

Aleutian Pribilof Islands Association, Inc. (APIA) Behavioral Health Clinic provides psychological and substance use assessments and treatment services, group therapy and intensive outpatient program (IOP) in Anchorage, Atka, Nikolski, Saint George and Unalaska. Our clinic's primarily focus is to provide services to beneficiaries belonging to APIA's service region. We also offer services to Alaskan Native and non-Native individuals depending upon our current clinic capacity.

Date of Referral: _____Send referral to: registration@apiai.org or fax: 907-222-4279

Referral to BH was discussed with client AND client agreed to be contacted ☐ YES ☐NO
Note**: BH staff cannot contact a person without knowledge of referral and agreement to contact.**

Person Being Referred: _____DOB: _____/_____/_____

Address: _____Phone Number: _____

Insurance:_____Email:_____

Referring Provider: _____ Direct Number: _____

Referring Facility:_____

Reason for Referral (Including description of the problem, how it affects the individual, if outside Anchorage why client cannot be served locally):

_____

_____

Requested Services: ☐ Psychotherapy ☐ Psychological Testing ☐ Intensive Outpatient Program

Other:_____

Has the client received services for behavioral health in the past year? ☐ No ☐ Yes

(Note we require a copy of the past 3 clinical chart notes for review at minimum.)

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Client History *(Please complete if self-referring for services or if clinical notes do not address questions below)*

Previous behavioral health diagnoses: ☐ None ☐ Yes, list_____

Current psychotropic medications: ☐ None ☐ Yes, list_____

If yes, is the client adherent with medications? ☐ No ☐ Yes

Historical or current suicidal/homicidal thoughts, ideation, plan, intent, or prior attempts? ☐ No ☐ Yes

If yes, please explain:_____

Historical or current self-harm behaviors? ☐ No ☐ Yes If yes, please explain:_____

_____

History of aggressive or violent behaviors towards others or destruction of property? ☐ No ☐ Yes

If yes, please explain:_____

Historical or current symptoms of psychosis ? ☐ No ☐ Yes If yes, please explain:_____

_____

Historical or current substance misuse? ☐ No ☐ Yes If yes, please list substance, method of use (e.g., smoking, IV, oral), overdose history, previous treatment programs, etc.:_____

_____

APIA will review the referral and records (if applicable) to determine if the outpatient clinic is a good fit for the requested services. For third party referrals, we will require a release of information for any future care coordination or if a higher level of care is needed.

Thank you for the opportunity to serve this client.

Referral Type (Administration Only):
□Tribal Health Organization □ Community Agency (Primary Care Clinic, Mental Health Clinic, etc.)
□ Self-Referral □ Office of children's Services (OCS) □ASAP □Other: _____