|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **REFERRAL FORM****Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****REFERRAL/INTAKE FORM** |  |  |  |  |  |  |
| **Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_****Race:** Circle one--White/Asian/African American/American Indian or Alaska Native/Native Hawaiian or other Pacific Islander**Ethnicity:** Hispanic, Latino, or Spanish? Yes or No |  |  |
|  |  |  |  |
| Client’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |   |  |  |  |
| County: \_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Referral Source (Name/Address/Phone):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |   |   |   |  |  |  |  |  |  |
| **Marital Status: Married \_\_\_\_\_\_ Single\_\_\_\_\_\_ Separated \_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_ Widowed\_\_\_\_\_** |  |
|  |  |  |
| Relationship to client: Self\_\_\_\_\_ Parent\_\_\_\_\_ Legal Guardian \_\_\_\_\_ Foster Parent \_\_\_\_ Other: \_\_\_\_\_\_\_\_ |  |
| Whom do we contact to set up appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Best time(s) to call? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone # to call:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Immunization Shot Record \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
| Date Requested \_\_\_\_\_\_\_\_ Fax/Mailed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Reason(s) for Referral (check all that apply)** |  |  |  |  |  |  |  |  |
| \_\_\_ Individual therapy \_\_\_ Substance Abuse \_\_\_ Parenting Classes |  |  |  |  |  |  |  |
| \_\_\_ Group therapy \_\_\_ Psychiatric Evaluation \_\_\_ Anger Management Classes |  |  |  |  |  |  |  |  |
| \_\_\_ Couples therapy \_\_\_ Medication Management \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| \_\_\_ PRP (if in therapy) \_\_\_ AIP (Abuser Intervention Program) Victim/Abuser (Circle One) |  |  |
| \_\_\_ Assess Competency to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |  |  |  |  |  |  |
| **Services Requested**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |
| **Brief Description of Problem** (use additional sheet if necessary. Please forward additional medicalBehavioral information, Court Reports, Evaluations, Social Summaries, etc):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Billing Information:**Medicaid #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |
| Other Insurance/Fee for Service/Uninsured (Circle one)Court Voucher/Other Payment Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Company/HMO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral Taken By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Intake Scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |