**REFERRAL FORM**

***Types of Services Requested:*   *Home Based*  *Office Based***

*Individual Therapy*  *Family Therapy* *Group Therapy (If available)*

***The following services depend on eligibility:***

*Individual Rehab*  *Group Rehab* *Case Management/Care Coordinator Services*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:

Parent(s)/Guardian(s):

Address: City, State, Zip:

Finding Directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2: E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: / / Age: \_\_\_\_\_\_ SS#: Insurance: \_\_\_\_\_\_\_\_\_\_\_\_

Ins. #: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_­­­­­­­\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_ Sex:  Male  Female Race/Ethnicity:

Presenting Problem(s)/History:

Anxiety  Aggression- Verbal  CWS/Foster Care

Attention/Concentration  Aggression-physical  Inpatient psych.

Depression  Neglect  Homicidal Thoughts

Grief and Loss Self-Mutilation  Suicidal Thoughts

Bi-Polar  Single Parent Family  Physical Abuse

Defiant/Oppositional  Blended Family  Sexual Abuse

Hyperactivity  Substance Abuse  Destroying Property

Learning Disability  Parenting skills

Autism

Schizophrenia

Temper Tantrums/Anger

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client aware that they are being referred for services:  Yes No

Does the client have any urgent needs? If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Is the client willing to come to the **office** to expedite the intake process? If yes, please state what day and time best suits the client’s availability for the intake? ***(Allow two hours for the intake process)*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anybody in the home smoke? If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any pets in the home? If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client/family have a preference regarding providers?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the client availability for services?  Days  Evenings Weekends Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Info: (Name, Phone #, **Email address**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If child is in DHS custody, please provide the DHS worker/supervisor contact information: (Name, Phone #, **Email address**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_