Referral must be filled out fully to be accepted

Choices For Life of Georgia, LLC

Behavioral Health Services Referral Form

2200 N Patterson Street

V: 229-244-1707 F: 229-244-1779

(Must be completed by referral source) **Date of referral:** _____

Name of Referral Source: _____ Contact Info: _____ Relationship to Child: _____

CHILD'S DATA:			
CHILD'S NAME: (Print Clearly)	**First Name**	**Middle Name**	**Last Name**
Date of Birth: **Age:**	**SS#:**		**Legal Status:**
Race / Ethnic Group:	**Gender:** **Female** ☐ **Male** ☐		**Referred by:**

Parent(s) / Legal Guardian / Emergency Contact Data:

Name: _____ Relationship: _____

Physical Address: _____ City/ State/Zip Code: _____

Telephone: _____ E-mail : _____

Preferred method of communication? (Circle One) Email Text Call Consent to ID and leave message? _____

Payor Source Data: **Medicaid Insurance accepted only. Tricare must be preapproved. No Private Insurance**

Payor Source: **Medicaid** ☐ **PeachState** ☐ **AmeriGroup** ☐ **CareSource** ☐

Insurance Policy Number: _____

☐ **Tricare Sponsors Name:** _____ **DOB:** _____ **Policy#:** _____

Services Offered/Requested: ☐ **Individual/Family Therapy** ☐ **Community Support Services**
☐ **Group Services** ☐ **Psychiatric Services** **Crisis Assessment** ☐ **Seven Challenges**

Presenting Problems: (Problem Behavior, community involvement, previous treatment if known)

Must be filled out with as much detail as possible.

SU Issues: ☐ **No** ☐ **Unknown** ☐ **Yes; Substance Used**: _____ **Last Use:** _____

Recent ER Medical/MH Services (location--- type of services received):

Medications currently prescribed/Prescribing Physician/ Pharmacy Used:

_____

Does the child require any hearing assistance? _____ **Desire to see CFL Physician?** _____

Name of Primary Care Physician: _____ **Last Seen:** _____

Name of Current School attending? _____ **Current Grade:** _____
How did you hear about Choices for Life? _____

Official Use

Eligibility Results: _____ **Date/Initials:** _____ **Deaf Screening Verification:** _____
Initial Contact Date(s): _____ **Method:** _____ **Initials:** _____
Appointment Date/Time: _____ **Referral Source notified:** _____
Assessor: _____ **Date/Initials:** _____