Choices For Life of Georgia, LLC

Behavioral Health Services Referral Form

2200 N Patterson Street

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

(Completed by Applicant and/or Legal Guardian)

Date of referral: _____

Person Making Referral: _____ **Contact Info:** _____

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 : _____

Payor Source Data:

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

Insurance Policy Number: _____ ☐ **Private Insurance Name:** _____

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

Services Offered/Requested: ☐ **Individual/Family Therapy** ☐ **Community Support Services** ☐ **Group Services** ☐ **Psychiatric Services** ☐ **Trauma Assessment**

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

SA 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:

_____

_____

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

Name of Current School attending? _____ **Current Grade:** _____

**********Official Use**********

Eligibility Results: _____ **Date/Initials:** _____

Initial Contact Date(s): _____ **Method:** _____ **Initials:** _____

Appointment Date/Time: _____ **Referral Source notified:** _____

Assessor: _____ **Date/Initials:** _____