

REFERRAL FORM

Date of referral:

*Name of Referral Source:		*Telephone #:		
		Email address:		
*Client's Current Guardian(s):		*Referral Source (School, DFCS, Parent):		
*Consumer Name: Last		First	MI	Other Names:
				*Sex:
				Ethnicity:
*Address	*City	State	*Zip Code	County
*Phone (Indicate: Home/Cell/Wk)	SS#	*DOB	*Client Lives With	Add. Phone

***Medical Coverage: List all that applies**

Medicaid #	PeachCare#	CMO Medicaid	Private Insurance	None	Unknown
		<input type="radio"/> Amerigroup <input type="radio"/> PeachState/Cenpatico <input type="radio"/> Wellcare/Magellan			

Service(s) Requested:

- | | | |
|--|--|--|
| <input type="checkbox"/> (IFI) Intensive Family Intervention | <input type="checkbox"/> Ind. Counseling | <input type="checkbox"/> Psychiatric Assmt |
| <input type="checkbox"/> Mental Health Assessment | <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Nursing Assmt |
| <input type="checkbox"/> Community Linkage (CSI) | <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Crisis Intervention |

1. *Presenting Problem (Include grief issues)																
2. History of Presenting Problem																
3. Current Medical Problems																
4. Current Medications																
5. History of Prior Psychiatric/Substance Abuse Treatment within past 3 years (if known)																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Problem/Diagnosis</th> <th style="width: 15%;">Dates</th> <th style="width: 40%;">Type of Treatment, Provider, Location</th> <th style="width: 20%;">Inpatient or Outpatient</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Problem/Diagnosis	Dates	Type of Treatment, Provider, Location	Inpatient or Outpatient												
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6. Additional Information																

*** Needed information to assess for referral**