Affinity Counseling Center

REFERRAL FORM

Date of referral:

Name of Caller:	**Telephone #:** **Email address:**
Client's Current Guardian:	**Referral Source (School, DFCS, Parent):**

Consumer Name: Last First MI			**Other Names:**	**Sex:** **Ethnicity:**
Address	**City**	**State**	**Zip Code**	**County**
Telephone (Home/Cell/Work)	**SS#**	**DOB**	**Legal Guardian/Parent**	**Telephone #**

Medical Coverage: *Check all that applies*

Medicaid #	**PeachCare#**	**CMO #** ○ **Amerigroup** ○ **PeachState/Cenpatico** ○ **Wellcare/Magellan**	**Private Insurance**	**Other**	**None**

Service Requested/Service Triage:

____ (IFI) Intensive Family Intervention
____ Crisis Intervention
____ Diagnostic Assmt/IRP
______ CSI (community support)
______ Ind. Counseling
______ Family Counseling
______ Group Counseling
______ Med Admin
______ Nursing Assmt
______ Physician Assmt
______ Pharmacy Svcs

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 and response to treatment *****If recent psychological evaluation available (within one year), please submit copy**

Problem/Diagnosis	**Dates**	**Type of Treatment, Provider, Location**	**Inpatient or Outpatient**

Response to Treatment (report any progress made)