Affinity Counseling Center

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** ○ **Amerigroup** ○ **PeachState/Cenpatico** ○ **Wellcare/Magellan**	**Private Insurance**	**None**	**Unknown**

Service(s) Requested:

____ (IFI) Intensive Family Intervention	_____ Ind. Counseling	_____ Psychiatric Assmt
____ Mental Health Assessment	_____ Family Counseling	_____ Nursing Assmt
____ Community Linkage (CSI)	_____ Group Counseling	_____ 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)

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

6. Additional Information

*** Needed information to assess for referral**

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