Referral Form

Date of Referral: ___________

(Please Print)

Name & Title of Person making referral: ____

Agency: __________________________ County: __________________ Court Mandated? ☐ Yes ☐ No

Phone # of person making referral: ___________________________ Fax number: ___________________

Email:________________________

How did you hear about us? __________________________________

Client Information:

Client Name: _______________________________ Guardian Name: _________________________

Medicaid#_____________

Date of Birth: ________________ Age: ______ SS#_________________________ Grade Level___________

Gender: (Please Check) ☐Male ☐Female Race: ____________________________

Placement Address: _______________________________City____________________________ State __________

Zip _________

Home Phone#: ________________________ Cell #: ________________________ Work #: __________________

Services Background:

1. Has the client had other services (e.g. CORE/IFI, Hospitalization, Individual and /or Family Counseling)?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
2. Does the client have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis?
   ☐ **Yes** ☐ **No** ☐ **Not Sure**
3. Has a Psychological/Psychiatric Evaluation been completed in the past? ☐**Yes** ☐**No** **If yes, please attach**

Service (s) Requested

☐ Psychological Evaluation ☐ Psychosexual Assessment ☐ Individual /Crisis Counseling ☐ Parental Fitness Evaluation ☐ Competency Evaluation ☐ Educational Assessment ☐ Forensic Evaluation ☐ Sex Offender Evaluation ☐ Diagnostic Assessment (verified diagnosis) ☐ Training/Supervision ☐ Other __________

Presenting Problem:

(List problem behaviors; include any medications for emotional and / or behavior problems)

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For Office Use Only:

Receipt Date: _____________ ***Insurance Active*** ☐***Yes*** ☐***No*** ***Medicaid Plan:*** ________________________

Assigned to: ______________________________ ***Date Assigned:*** ___________________________________

Assessment Completion Date: ________________ ***Consumer Approved?*** ☐***Yes*** ☐***No***

If not approved, why? ____

If approved, approval date? _______________**Fee** ___________________**Payor Source**___________________________