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REFERRAL FORM

School / Agency: ______________________ Date of Referral: ______________

Type of Service Requested: ☐ Community-Based ☐ Tageted Case Management ☐ Assessment/Screening

Name of Person Making Referral: ______________________________

Phone: ______________ Email: ______________________

Last Name: ______________ First Name: ____________ MI: _____ Sex: ☐ M ☐ F DOB: __________

Address: ____________________ City: ______________ State: _____ Zip: __________

Phone: ______________ RECORD: ______________ Social Security # ______________

Primary Language: ______________ Race: ___________ Ethnicity: ______________

PRIMARY PAYMENT SOURCE:

Insurance: ______________ ☐ No Insurance ☐ Medicaid MID#: ______________

Parent/Guardian: ______________ Daytime Phone: ___________ Primary Language: __________

Address: ____________________ City: ______________ State: _____ Zip: __________

Brief history & chief complaint / presenting problem:

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Check all that apply

☐ Dangerous Behaviors ☐ Substance Use/Abuse ☐ Thoughts of Suicide

☐ School Problems ☐ Family Problems ☐ History of Abuse

Primary Care Name: ______________________________

Address: ______________________________ Phone: ______________

Allergies: ______________________________

Medication(s) / Medical issues: ______________________________

______________________________ ______________

Signature of Referral Person Date