DATE OF 1st CALL:

INITIALS FILLING OUT:

ELATED
counseling services llc

Referral Form for Mental Health Services

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ☐ Male ☐ Female	Maritial Status:	Circle One:
Services Requested: ☐ Office-Based Outpatient ☐ Community-Based (if therapist is available)		
Service Location: ☐ Office ☐ Home ☐ School (if appropriate)		
CONTACT NUMBERS:	Voicemail ok? ☐ Yes ☐ No	
ADDRESS:		

Parent or Legal Guardian Information: If applicable

Name of Parent or Legal Guardian:	Department:
Contact Numbers:	Type of setting: ☐ Home ☐ Group Home ☐ Foster Home ☐ Psychiatric hospital ☐ Other

Payment Information:

Type of Insurance ☐ Medicaid (county) ☐ Commerical Insurance Name:	GROUP#
Insurance ID#	Phone #

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about Elated Counseling?	

Adult or Child Mental Health Information:

Current medication & dosage	Current Diagnosis
	Prescribed Reason:
	Prescribed Reason:
	Prescribed Reason:
	Prescribed Reason:
Prescribing Physician name & Phone	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

_____

_____

_____

Additional Comments _____

_____

Has the client received treatment before?: _____

Availability: _____

2020 East 70th Suite 201, Shreveport, LA 71105
Phone (318) 751-9098 – Fax (318) 751-9099
www.elatedcounseling.com