New Referral Form

Email form to: indigenous.health@outlook.com

Referral Date: _____

Client Name: _____Medicaid/AG/HPN/SS #: _____

Date of Birth: _____ Client Age: _____ Female____ Male_____

Phone: _____ Address: _____

Parent/Legal Guardian: _____ Relationship: _____

Tribal Affiliation: _____ Federal Enrollment Number: _____

Race/Ethnicity (Choose more than one if bi-racial)

☐ Caucasian ☐ African American ☐ Hispanic

☐ American Indian/Alaskan ☐ Pacific Islander ☐ Asian ☐ Other_____

Referral Source Information

Name: _____ Agency/Relationship: _____

Contact Phone: _____

Special Instructions/Information: _____

_____

Any previous diagnosis? _____Yes _____ No _____N/A

If yes, please provide diagnosis: _____

Services Requested

☐ **Basic Skills** ☐ **Psychosocial Rehabilitation** ☐ **Case Management** ☐ **Day Treatment**

☐ **Individual Therapy** ☐ **Couples/Family Therapy** ☐ **Group Therapy**

☐ Emergent ☐ Urgent ☐ Routine

Same Day Start Service 1-2 Days Start Service 48 to 72 Hour Start Service