A BETTER U
Behavioral Health

Service Referral Form

Name			Age:
Marital Status: (circle one) Never Married Married Widowed Separated/Divorced			Ethnicity: (circle one) 1. non-Hispanic. 2. Hispanic
Race: (Check one) 1. White ☐ 2. Black/African American ☐ 3. Asian/Pacific Islander ☐ 4. American Indian ☐ 5. Alaskan. ☐ 6. Other ☐			
Date of Birth:	Sex:	Veteran: Yes/No	SSN:
Parent or Legal Guardian Name (If Applicable)			
Street:			
City:	Zip Code:		County:
Current Living Arrangements: 1. Adult only 2. Adult: Relative 3. Adult: Non-Relative4. Child: Both Parents 5. Child: One Parent 6. Child: Relative7. Child: Foster Family 8. Widowed			
Home Phone:	Mobile:		Email:
School (if applicable):	Current Grade:		
Referral Source: (Agency, School)	Emergency Contact:		
Name of Person Submitting Referral:	Contact Telephone Number:		
Insurance Name:	Client Medicaid #:		
Reason for Referral (circle all that apply and briefly explain): Depression/Sadness Anger Excessive Worry Trauma Uncontrolled Behavior Difficulty Sleeping Hyperactivity Difficulty with Focus/Concentration			

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