Blue Stream Healthcare

Bluestreamhealthcare.com

REQUEST FOR SERVICES

Name: _____ Age: _____ D.O.B.: _____
(Please Print - Last Name, First)

SSN: _____ - _____ - _____

Gender: [ ] Male [ ] Female Ethnic Group: _____
Primary Language: [ ] English [ ] Spanish [ ] Creole [ ] Other: _____

School (If Applicable) : _____ Grade: _____
School Status: [ ] Passing [ ] Failing [ ] Truant [ ] Drop Out [ ] Suspended [ ] Other: _____

[ ]Parent/[ ]Guardian Name: _____ Home Phone: (___) _____
(Last Name, first) Cell: (___) _____
Email: _____

Address: _____

City/ST: _____ Zip Code: _____

Name of Insured: _____ Insurance Company Name: _____
Claim #: _____

Services Requested: [ ] General Counseling [ ] Therapy [ ] Community Support and Rehabilitative Services
[ ] Assessment [ ] Medication Management [ ] Other: _____

Are requested services mandated by court? [ ]Yes [ ]No If yes, court date: _____
Pending Charge: _____ Case Number: _____
Probation Officer: _____ Telephone: (___) _____
Legal Representative: _____ Telephone: (___) _____

Issues Reported

☐ Self-Esteem -Experimentation	☐ Depression	☐ Family Interaction	☐ Substance Use
☐ Conflict Resolution	☐ Sexual Physical Abuse	☐ Peer Relations Social Skills	☐ Substance Abuse
☐ Repression of Anger	☐ Time Management	☐ Parenting Issues	☐ At Risk Substance Use/Abuse
☐ Juvenile Delinquency	☐ Medical Problems	☐ Physical Health Problems	☐ Educational Disability
☐ Legal Issues	☐ Medication Management	☐ Vocational Job	☐ Other:

Referring Entity and/or Guardian's reason for requesting services: _____
Telephone: (___) _____ FAX: (___) _____
Person Making Referral/Title: _____

_____ _____
(Signature) (Date)

Clinical Support Office Use Only

Date Received by Office: _____ Eligible for Services? [ ] Yes [ ] No

Date out to/Intake Specialist: _____ Date Returned: _____

Date out to/Assessment Unit _____ Date Returned: _____
Practitioner Name /Date Assigned to Practitioner: _____