Latino Leadership Behavioral Health

Referral Form

DEMOGRAPHIC INFORMATION

Name: _____ Social Security #: _____
Parents/Caregivers Names: _____ Relationship to Client: _____
Address: _____
City/State: _____ Zip Code: _____ County: _____
Phone: _____ Phone #2: _____ Email: _____ Sexo: M F
Race: White/Black/Hisp/Asian/Haitian/Bi-Racial Birth Date: _____ Age: _____
Legal status: _____ Minor in parent/guardian custody _____ Minor in state custody
_____ Competent Adult _____ Incompetent Adult _____ Other: _____
School/Employer: _____
Caregiver's primary language: _____ Bilingual needed: _____ Yes _____ No

OTHER CURRENT SERVICES

____ No current services
Mental Health Counseling: _____
Name/Agency: _____ Phone: _____
Psychiatric Services/Medication: ____ Yes ____ No _____
Name/Agency: _____ Phone: _____

REFERRAL SOURCE INFORMATION

Referring Agency: _____ Referring Person: _____
Phone: _____ Fax: _____ Email: _____ Date: _____
SERVICES REQUESTED: Individual/family therapy*Marriage Counseling*Group Therapy*Parenting Classes

FUNDING INFORMATIION

Medicaid#: _____ Medicaid type: _____
Other insurance: _____ ID #: _____ Grupo #: _____
Insurance Phone/Address: _____
Authorization Details: _____

PROBLEM DESCRIPTION

Please check the client's current behavioral/emotional symptoms (required):
*Physical Aggression *Runaway *Tantrums *Lying *Depression *Verbal aggression *Property destruction *Truancy *Sexually acting out *Anxiety *Non-compliance *Disruptive behavior *Stealing *Alcohol/Drug Problem *Domestic Violence *Self-injury/Suicidal *Toileting problems *Language delayed *Self-care problems *Developmental delay *Autistic/ASD *Other symptoms or further information: _____
_____

FOR LLBH PROGRAM USE ONLY

Date Received: _____ Date assigned: _____
Clinician Assigned: _____ Licensed Evaluator: _____
Status: ____ Pending ____ Waiting ____ Hold