Special Hands Outreach

1910 Towne Center Blvd. Suite 250 Annapolis, MD 21401

443-256-5290

care@specialhandsoutreach.org

SPECIAL HANDS OUTREACH — REFERRAL FORM

Date of Referral: _____

CLIENT INFORMATION

- **Client Name:** _____
- **Date of Birth:** _____ **Age:** _____
- **Parent/Guardian Name (for minors):**
  _____
- **Relationship to Client:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Address (City & State):** _____

INSURANCE INFORMATION

- **Insurance Provider:** _____
- **Member ID #:** _____
- **Policy Holder Name:** _____
- **Policy Holder DOB:** _____

REASON FOR REFERRAL

(Please briefly describe the client's needs and goals for treatment.)

_____

_____

_____

CURRENT SYMPTOMS / CONCERNS

(Check all that apply)

☐ Depression
☐ Anxiety
☐ Trauma / PTSD
☐ Behavioral Concerns
☐ Grief / Loss
☐ ADHD
☐ Social Anxiety
☐ Emotional Regulation Difficulties

☐ School Difficulties
☐ Family Conflict
☐ Relationship Concerns
☐ Other: _____

SAFETY CONSIDERATIONS

- Has the client experienced recent trauma? ☐ Yes ☐ No
  If yes, please describe: _____
- Any safety concerns (self-harm, suicidal thoughts, aggression, etc.)? ☐ Yes ☐ No
  If yes, please describe: _____

REFERRING ORGANIZATION / PROVIDER INFORMATION

- **Organization / Agency Name:** _____
- **Referring Provider Name:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Preferred Method of Follow-Up:** ☐ Phone ☐ Email

ADDITIONAL NOTES

_____

_____

_____

NEXT STEP

Once this form is completed, please send it to:
📧 **admin@specialhandsoutreach.org**
📞 **443-256-5290**