ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls

REFERRAL FORM

Please print

Clients Name: _____ DOB: _____ Address: _____ Phone#: _____	**Referring Agency:** _____ Address: _____ Phone#: _____ Fax#: _____
Parent/Legal Guardian:	
Type of Insurance:	Insurance ID#:
Date of Referral:	Person completing form:
List CURRENT MEDICATION(S)/Dosage: 1.) _____ 2.) _____ 3.) _____ 4.) _____ 5.) _____	**Presenting Concerns:** 1.) _____ 2.) _____ 3.) _____ 4.) _____ 5.) _____
Current Diagnosis: AXIS I: _____ AXIS II: _____ AXIS III: _____ AXIS IV: _____ GAF Score: _____	**Prior Treatment (from referring agency):** _____ _____ _____ _____ _____ Effective: yes no

Mental/Medical History(Check all that applies):		**Services Requested**(Check all that applies):	
Drug Addictions/Use		Clinical Assessment:	
Drug Overdose:		Diagnostic Assessment:	
Correctional Facilities:		Outpatient Therapy:	
Suicidal Ideations:		Medicine Management:	
Homicidal Ideations:		Annual/Re-Assessment:	
Physical Abuse:		Psychological Evaluation:	
Sexual Abuse:			
Mental Health Institution(s):			
Outpatient Therapy			
Medicine Management:			
Hospitalization:			

Checklist for Appointment:	
1.)Copy of Insurance Card	2.) Assessment(s) conducted within the last 2 years.
3.) Background Information	4.) Special Needs:

This Section to be filled out by Alase Center for Enrichment II*

Appointment Scheduled: ___ Yes ____ No

Appointment Date and Time: _____

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