NEW CLIENT REFERRAL FORM

Last Name _____ First Name _____ Middle Initial: _____

DOB ____/____/_____ SS# _____ Sex _____ Race _____ Email _____

Address _____ Apt # _____

City _____ Zip _____ +_____ County _____

Email _____

Has the client had mental or behavioral health services/treatment in the last 12 months? ___N ___ Y (Where :_____)

DJJ Involvement? ___Y ___N DCF Involvement? ___Y ___N Client's primary language? _____
(If the child is involved with Child Welfare Case Management, please send Shelter Order. Intake packet will be sent to DCM)

Parent/Guardian Name: _____ Relationship to Child: _____

Ph (_____) _____ Ph (_____) _____Parent's primary language: _____

With whom does child **reside**? _____** If child does not reside with parent(s), guardian must provide legal documentation supporting the ability to consent to treatment. This includes step-parents, grandparents & other caregiver.

Name of School Client attends: _____

Medicaid Insurance Plan: _____ ID Number: _____ (___) I also have a commercial plan

Commercial Insurance Plan: _____ ID Number: _____

Primary Reason for Referral (CHECK ALL THAT APPLY)

___Anxiety
___Inattention/Hyper
___Verbal Aggression
___Substance Abuse
___Sexual Acting-Out
___Trauma / Grief
___Low Self Esteem
___Depression
___Social Skills
___Non-Compliance
___Bullying
___Family Issues
___Physical Aggression
___Defiance/Disrespect
___Post Adoption Issues
___Dependency
___Psychosomatic
___Recent Baker Act

Referral Source:

Name: _____ Agency: _____ Email: _____

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