NEW CLIENT REFERRAL FORM

Date: _____ / _____ / _____

Email: Referrals@BigBearCounseling.org **Call: 800-840-2528** **Fax: 407-540-9552**

Client Information (please print):

Last Name _____ First Name _____ Middle Initial: _____

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

Address _____ Apt # _____

City _____ Zip _____ +_____ County _____

Has the client had mental or behavioral health services/treatment in the last 12 months? ___Y ___N
If yes, where? _____When did services end? _____

DJJ Involvement? ___Y ___N
DCF Involvement? ___Y ___N
Client's primary language? _____
Child Welfare Case Management Involvement? ___Y ___N

(If the child is involved with Child Welfare Case Management, please send Shelter Order. Intake packet will be sent to DCM)

Parent / Guardian Information (for minor clients only):
Parent/Guardian Name: _____ Relationship to Child: _____

Ph (_____) _____ Cell (_____) _____

Parent's primary language: _____ Bilingual therapist required? Yes No

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 and other relative caregivers.

Name of School Client attends:_____ Grade: _____

Insurance Information:

**We accept the following insurance plans: FL Medicaid & all MMAs, Healthy Kids, In-State Florida Blue, & CMS. Please specify which plan.

Insurance Plan: _____ ID Number: _____

Primary Insured's Name: _____ DOB: _____

Other form of payment: _____Self Pay _____ FSPT _____Other: _____

Referral / Treatment Needs

Primary Reason for Referral (CHECK ALL THAT APPLY)

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

Service(s) Desired

___ Psychiatry/Med Mgmt
___ Individual Counseling
___ Family Counseling
___ Group Counseling
___ Targeted Case Mgmt
___ Therapist Supervised Visitation (TSV)

Other Reasons/Additional Information: _____

*If referring for TSV, please make sure to send all demographic information for the parent/caregiver with whom the child is visiting.

Referral Source:

Name: _____ Agency: _____

Phone: _____ Email: _____