|  |  |  |
| --- | --- | --- |
| **Intake form:** | **Date:** |  |
| **Services:**  | **❑in home outpatient** | **❑Outpatient**  | **❑CSP** | **❑ OTHER**  |  |
| **Method:**  | **Phone** | **Fax** | **Agency: EOPC Dedham OFFICE** | **probation: Adult Juv** |
| **Referral source:** |  | **agency:** |  | **phone#:** |  |
| **Consumer Information: (1st Name) (last name)**  |
| **Name:**  |  |  | **Sex:**  | **❑Male** | **❑ Female** |
| **Current address:**  |  | **Apt #:**  |
| **City:**  |  | **State:**  |  | **ZIP Code:**  |  |
| **Date of Birth:** |  | **S.S #:**  |  | **Age:**  |  |
| **Ethnicity:**  |  | **Language Spoken:**  |  |
| **Best phone #:**  |  | **Secondary phone#:**  |  |
| **Emergency Contact (Name):**  |  | **Emergency (phone #)**  |  |
| **Parent/Guardian (18 & under):** |  | **Current School:** |  |
| **Insurance Information** | **Member Insurance ID:**  |  |
| **❑ MBHP**  | **❑NHP**  | **❑BMC**  | **❑BC/BS**  | **❑Medicare**  | **❑Celticare**  | **❑Tufts/Network** | **❑ Other:** |
| **Reason for referral (Presenting Issue):** |
|  |
| **Clinical Information** |
| **Does client have outpatient services? -YES -NO N/A (if yes)****(Name) (Agency) (Contact #)** |
| **Is Client currently: Suicidal Yes No N/A OR Homicidal Yes No N/A** |
| **Is client currently Hospitalized? : Yes No Where?** |
| **Requested current treatment plan/goals from provider?**  |
| **Is client in a dangerous situation? : Yes No (If yes, follow emergency protocol)** |
| **Have they ever been a victim of violence or crime in the past? YES NO N/A****Is this impacting/affecting your decision to come to counseling? YES NO Incident? :** |
| **Have they ever tried to quit using a substance? YES NO N/A** **Cigarettes Alcohol Drugs (type):** |
| **Disposition (Administrative use only)** |
| **Accepted for service-appointment**  | **Date:**  | **Time:** |
| **Assigned Provider(s):** |
| **Referred elsewhere? Yes NO IF yes, why?**  |
| **Waiting list date:** | **Informed referrer date:** | **Informed family date:** |
| **Final Disposition: Assigned Referred Out Unassigned (closed out)** |
| **Returning Consumer? Yes No** | **MIS #:**  | **\*\*Contact Referral & Document all contact in notes. \*\*** |
| **Notes (Additional information)** |
|  |