

**Referral Form for Mental Health Services**

**Client Information**

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| --- |
| Name: Date of Birth: Race/Ethnicity: |
| Gender: ❒Male ❒Female ❒Couple |
| Services Requested: ❒Individual Therapy ❒Family Therapy |
| **CONTACT NUMBER:** Message ok? ❒Yes ❒No |
| **ADDRESS:** |

**Parent or Legal Guardian Information:**

|  |
| --- |
| Name of Parent or Legal Guardian: Address: |
| Contact Number: |

**Payment Information:**

|  |
| --- |
| Type of Insurance ❒Medicaid ❒Private/Employer ❒Private Pay  If no insurance, household income: |
| Insurance ID# Phone # |

**Referral Source Information:** Complete this section so we can contact you after the referral is made.

|  |
| --- |
| Name: Mailing Address: |
| Contact Number: Email address: |

**Child/Adult Mental Health Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current medication & dosage Current/Previous Diagnosis | | | | | |
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|  | | | | | |
| Prescribing Physician name & Phone | | | | | |
| **Current Mental Health Symptoms:** | **Unknown** | **Not Present** | **Mild** | **Moderate** | **Severe** |
| Hallucinations (describe) |  |  |  |  |  |
| Delusions |  |  |  |  |  |
| Thought disorder/Preoccupation |  |  |  |  |  |
| Bizarre (psychotic) behavior (describe below) |  |  |  |  |  |
| Anxiety / Nervousness |  |  |  |  |  |
| Obsessive / compulsive |  |  |  |  |  |
| Phobias / fears |  |  |  |  |  |
| Depressed mood |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| Sleep disturbance |  |  |  |  |  |
| Irritability |  |  |  |  |  |
| Anger / temper tantrums |  |  |  |  |  |
| Hyperactivity |  |  |  |  |  |
| Attention deficit |  |  |  |  |  |
| Eating problems |  |  |  |  |  |
| Elimination problems |  |  |  |  |  |
| Oppositional / defiant to those in authority |  |  |  |  |  |
| Antisocial / delinquent behavior / conduct disorder |  |  |  |  |  |
| Over sexualized behavior |  |  |  |  |  |
| Somatic complaints with no known medical cause |  |  |  |  |  |
| Attachment disorder (explain below) |  |  |  |  |  |
| Other (explain) |  |  |  |  |  |

**Reason for referral for treatment:** In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting (if applicable).

**Additional Comments**

Been in counseling before?:

Availability: