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MENTAL HEALTH
PROGRAM REFERRAL FORM

REFERRAL SOURCE INFORMATION

Date of Referral: _____ School Location (If Applicable): _____

Referring Agency/Address: _____

Referring Worker (title and credentials): _____ Phone_____

Email Address: _____ Fax Number: _____

CLIENT INFORMATION

Consumer Name: _____ Gender: _____ Marital Status: _____

SSN: _____ DOB: _____ AGE: _____ RACE: _____

Medical Assistance #: _____ Legal Guardian: _____

Full Address: _____

Phone: _____ Alternate Phone: _____

Foster Parent: No Yes (If so please provide a copy of the court order)

School: _____ Grade: _____

Services Requested:

- ❑ Mental Health Evaluation/ Assessment
- ❑ Individual Therapy/Family Therapy/Group Therapy
- ❑ Case Management
- ❑ Medication Management
- ❑ Psychiatric Rehabilitation Services (PRP)
- ❑ Diagnostic Testing

Presenting Problems:

_____

_____

Current Medications: (Please include name and dosage)

Has the consumer recently been discharged from therapy services? No Yes, if so why? _____

_____

Has the consumer been arrested in the past six months? No Yes, if so how many times? _____

Is the consumer a Veteran? No Yes

FOR COMMUNITY CARE STAFF USE ONLY

Insurance Authorization #:_____ # of Authorized visits: _____
Dates of Authorization: _____ to _____
Date Assigned: _____