CRABTREE
Counseling & Consulting
commit~connect~change

REFERRAL FORM

Referred by: _____
Referring Agency: _____

Referral's Phone: _____
Referral Date: _____

REQUESTING:

☐ Comprehensive Clinical Assessment
☐ Outpatient Therapy

CONSUMER INFORMATION

Consumer's Name: _____
Date of Birth: _____ Social Security #: _____
Medicaid Number: _____ Expires: _____
Street Address: _____
City/State/Zip: _____ County: _____
Home Phone: _____ Email : _____

Marital Status: ☐ Married ☐ Single
Gender: ☐ Male ☐ Female

Race/Ethnicity: _____
School/Grade: _____

Is there a history of treatment? (Please check one) ☐None ☐Unknown ☐Psychiatric ☐Substance Abuse

FUNDING SOURCE

☐Medicaid ☐Health Choice ☐BCBS: _____ ☐ Medcost ☐ Optum
Secondary insurance: _____
Primary Insurance #: _____ Secondary Insurance #: _____

FAMILY OR LEGAL GUARDIAN INFORMATION

Mother's Name: _____ Father's Name: _____

If the consumer does not live with either parent who is the legally responsible person?

Person's Name: _____ Phone number: _____

Email Address: _____

PRESENTING PROBLEM OR REASON FOR SEEKING SERVICES:

☐ Grief/Hopelessness
☐ Feelings of Hopelessness
☐ Social Isolation
☐ Impulsive Decisions or Irritability
☐ Argues with adults
☐ Difficulty at work/school
☐ Trying to reach goals, but an underlying issue may be getting in the way
☐ Emotional Outburst
☐ Mood Swings
☐ Exposed to domestic violence
☐ Guilt/Anger
☐ Difficulty Sleeping
☐ Difficulty staying on task
☐ Placing yourself or others in a dangerous situation
☐ Crying spells
☐ Suicidal/homicidal thoughts
☐ Battling drug use or addiction
☐ Easily loses temper
☐ Weight Loss/gain
☐ Poor social behavior
☐ Blames others for behavior issue and/or mistakes

Other: _____