



Fax: 1.866.390.3048 | Email: referrals@unitedhumanservices.com
| Office: 346.330.9853

Referral Form

Name: _____ DOB: ____/____/____

Legally Responsible Adult, if applicable: _____

Gender: [] Female [] Male Race _____

Address: _____

Home Phone #: _____

Insurance:

___ Medicaid # _____

___ Other Insurance: _____ # _____

___ Policy Holder if Private Employer Insurance _____

Referral Source: _____ Date of Referral: _____

➤ Contact Information: Phone: _____ Email: _____

If child-adolescent: School: _____ Grade: _____ Special Program: _____

Presenting Problems: _____

Parent notified by Counselor/school personnel: _____ Counselor Email: _____

Suicidal or Homicidal: ___ No ___ Yes _____

Substance Use/Abuse: ___ No ___ Yes _____

Legal Involvement: ___ No ___ Yes: _____

Involvement with Other Agencies (DSS, DJJ, Probation/Parole, etc): ___ No ___ Yes: _____

Known Allergies: _____

*****OFFICE USE*****

Disposition: Accepted for services yes _____ no _____ If no explain _____

Need identified as: ☐ urgent (w/in 2 hrs.) ☐ Immediate (w/in 24 hours) ☐ Emergent (w/in 48 hours) ☐ Routine (w/in 5 business days)

Initial Appointment Scheduled: ___ No ___ Yes: Date: _____

Interview with referral source: ___ No ___ Yes: Date _____

Consent to release information about disposition to referring source/agency: [] Yes [] NO

Referring source/agency was informed of eligibility or ineligibility of service by:

URC Contractor: _____ Date: _____

If not accepted for services, please list any recommendations provided to Individual:

(1) (2)

(3)

UHS Representative, Title

Date