Fax: 1.866.390.3048 | **Email**: admin@unitedhumanservices.com | **Office:** 346.330.9853

Lamar CISD 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