REFERRAL INFORMATION

Date of Referral:	
Referral Source (who is completing this form): ☐Parent/Guardian ☐ DJJ ☐ DFCS ☐DA's Office ☐Other: _____	
Referral Source Name/Agency:	Referral Title:
Referral Source Phone:	Email:
Services Requested: Fee-Based	
☐Outpatient Therapy	☐ Assessment ☐ Counseling ☐ In-Home Case Management ☐ In-Home Intensive Treatment ☐ Crisis Intervention – Prevent Placement Disruption ☐ Crisis Intervention – Behavior Management **Specialized Therapy:** ☐ Child Parent Psychotherapy (CPP) ☐ Trauma Focused CBT (TF-CBT) ☐ Comprehensive Trauma Informed Assessment (CTIA) ☐ Cognitive Processing Therapy (CPT) ☐ Problematic Sexual Behavior (PSB) Assessment and/or Therapy **(if PSB, please complete PSB Supplement on Page 3)** ☐ Cognitive Processing Therapy (CPT) ☐ Medication Management (in conjunction with Therapy at OneSource
☐Transportation	**Requested for:** ☐ Work ☐ Non-Emergency Medical ☐ Court ☐ Visitation ☐ School/GED ☐ Other _____
☐Behavior Aide Services	Purpose:
☐Out-of-School	☐ Before School ☐ After School ☐ Summer Academy County: _____
Services Requested: Free Community Services	
☐ Mentorship ☐ Food/Clothing Pantry ☐ Educational Counseling ☐ GED/Wrap around ☐ Vocational Training ☐ Career Assessment ☐ Career Development/Couseling ☐ Employment Assistance ☐ Soft Skills ☐ Life Skills Workshops ☐ Entrepreneurship Classes ☐ Housing Assistance ☐ Fatherhood Program ☐ Parenting Support ☐ Attorney Consultation	
Briefly describe why you are referring client?	

CLIENT INFORMATION

Client Name:	DOB:	Age:
Where is client currently residing? (Home, Psychiatric Residential Treatment Facility, Hospital, Etc.):		
Client Address (include city and zip code):		
Client Race:	Gender:	Marital Status:
Client Insurance:	Insurance #:	If Medicaid, MCO:
Primary Language Spoken at Home:	Legal Involvement: ☐ Yes ☐ No	
If Client is a child, is client served by an Individualized Education Plan (IEP) or 504 Plan: ☐ Yes ☐ No		

Parent/Guardian Information (Please complete this section if client is a child)

Parent/Guardian Name:		
Parent/Guardian home phone:	Work/Cell:	
Parent/Guardian Address:	City:	Zip:
Caregiver's Name if different than Guardian(s):	Phone #:	
What is the child custody status (if parents are divorce or separated)?		

Other Agencies/Service Providers Involved with Client (e.g., Outpatient Therapist, Psychiatrist, etc.)

Name of Agency/Provider	Contact Name	Contact Phone #

Please email Encrypted Referral or Password Protected Form to Intake@Onesourcega.org or Fax To (404) 891-4788.

If you are referring for Problematic Sexual Behaviors, please complete the PSB Supplement on page 3. →

Problematic Sexual Behavior (PSB) Supplement

***Please Note:** We *cannot* schedule an initial appointment until all requested documentation has been received. **

Complete for child clients with PSB needing therapy, psychosexual risk assessments, or court ordered evaluations. The information is required to link the client to the most appropriate service and clinician.

Check all that apply:

Does the client have any pending legal charges? ☐ Yes ☐ No

Has the client been court ordered to receive a psychosexual risk assessment? ☐ Yes ☐ No

Has the client had a previous psychosexual evaluation? ☐ Yes ☐ No When and where?

****Please include a copy of any of the following materials applicable to this case: Current and previous mental health providers, psychological examinations, IEP report, CME, etc.**

Describe in as much detail as possible the problematic sexual behaviors prompting this referral (how old the client was at the onset of the PSB, how long the PSB has been occurring, and how often it has occurred). Please describe if the client has received previous treatment or evaluations related to the PSB.

Department of Juvenile Justice (DJJ) Referrals ONLY

Please complete the following if referral is from the DJJ:

Youth's legal status ☐ Pre-adjudication ☐ Pre-sentencing ☐ Post-conviction ☐ Post-placement	
Court Counselor *(if different from referral source):*	Phone:
Original charge(s):	
Reduced charge(s):	
Date evaluation is due in court:	NC JOIN #:
***Please include a copy of any of the following materials applicable to this case: Court Judgement or Order, Arrest Report, Witness Statement, Police Reports, Offender Statement, Victim Statement, CME, etc.**	