Peculiar Counseling & Consulting, PLLC

PLEASE FAX COMPLETED FORM TO INTAKE SPECIALIST
(336) 285-7868 F

FOLLOW UP CALL MAY BE PLACED TO
(336) 285-7616P

REFERRAL FORM

Referred By: _____ Referral's Phone: _____

Referring Agency: _____ Referral Date: _____

- **REQUESTING:**

☐ Diagnostic Assessment ☐ Intensive In-Home ☐ Medication Management
☐ Community Support Team ☐ Psychosocial Rehabilitation ☐ Substance Abuse Services
☐ OPT: _____ ☐ Comprehensive Clinical Assessment

- **CONSUMER INFORMATION**

Consumer's Name: _____

Date of Birth: _____ Social Security #:

Medicaid Number: _____ Expires: _____

Street Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Marital Status: ☐ Married ☐ Single Race/Ethnicity: _____

Gender: ☐ Male ☐ Female School/Grade: _____

Employer's Name: _____ Occupation: _____

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

- **FUNDING SOURCE:**

☐ Medicaid ☐ Health Choice ☐ Other: _____

- **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: _____

- **CURRENT MEDICATIONS** (Please include name, frequency, and dosage):

_____

- **PRESENTING PROBLEM OR REASON FOR SEEKING SERVICES:**

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