**REFERRAL FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referred By: |  |  | Referral’s Phone: |  |
| Referring Agency: |  |  | Referral Date: |  |
|  |
| **REQUESTING:** |
| [ ]  Clinical Assessment [ ]  Substance Abuse Treatment [ ]  Outpatient Therapy [ ]    [ ]  OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CONSUMER INFORMATION : RECORD#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Consumer’s Name: |  |
| Date of Birth: |  |  | Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| --- |
| **FUNDING SOURCE:** |
| [ ]  Medicaid [ ]  MedicareCounty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Health Choice | [ ]  BCB [ ] TriCare [ ]  ChampVA [ ]  Self Pay / Other  |  |
|  |

Primary Insurance #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ exp:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Insurance#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ exp:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 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 |
|  |  |  |  |
| **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: |  |
| **PRESENTING PROBLEM OR REASON FOR SEEKING SERVICES:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |