**REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referred By: |  | | | | |  | | | Referral’s Phone: | |  | | |
| Referring Agency: | |  | | | |  | | | Referral Date: |  | | | |
|  | | | | | | | | | | | | | |
| **REQUESTING:** | | | | | | | | | | | | | |
| Clinical Assessment  Substance Abuse Treatment  Outpatient Therapy    OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  | | --- | --- | |  |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **CONSUMER INFORMATION : RECORD#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| Consumer’s Name: | |  | | | | | | | | | | | |
| Date of Birth: | |  | | | |  | | | Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
| |  |  |  |  | | --- | --- | --- | --- | | **FUNDING SOURCE:** | | | | | Medicaid  Medicare  County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 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:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |