

DATE \_\_\_\_\_

TIME \_\_\_\_\_

REFERRER \_\_\_\_\_

ORGANIZATION \_\_\_\_\_

PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

SERVICES REQUESTED

- OFFICE-BASED: INDIVIDUAL/FAMILY
- TREAT FIRST
- MULTISYSTEMIC THERAPY (MST)
- PROBLEM SEXUAL BEHAVIOR (MST-PSB)
- THRIVING KIDS PARENTING PROGRAM
- FOSTERING FAMILY
- INFANT MENTAL HEALTH (IMH)
- COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS)

REASON FOR REFERRAL

Legal Involvement. Charged with: \_\_\_\_\_

Problem Sexual Behavior. Describe: \_\_\_\_\_

Physical Aggression     Verbal Aggression     Academic Issues     Substance Use/Abuse

Running Away     Negative Family Conflict     Negative Peer/Gang Involvement

Other: \_\_\_\_\_

CLIENT INFORMATION

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

SSN \_\_\_\_\_ CITY/TOWN \_\_\_\_\_ SPANISH REQUIRED?  YES  NO

LEGAL GUARDIAN \_\_\_\_\_

RELATION TO CLIENT \_\_\_\_\_ PHONE \_\_\_\_\_

IF LEGAL OR CYFD INVOLVEMENT, FACTS # \_\_\_\_\_

STATUS OF LIVING SITUATION AT TIME OF REFERRAL:

- At Home With Caregiver     Living With Other Family Members     In Detention
- In Residential Treatment     In TFC     In Shelter

**CONTINUED ON PAGE 2 >**

PAYMENT INFORMATION

CLIENT IS LEGAL U.S. RESIDENT?  YES  NO

CLIENT HAS MEDICAID:  YES  NO

IF YES: MEDICAID # \_\_\_\_\_

CENTENNIAL HEALTHCARE # \_\_\_\_\_

RECERTIFICATION DATE \_\_\_\_\_

CLIENT HAS ACCEPTED PRIVATE INSURANCE?

Blue Cross & Blue Shield

Presbyterian Health Plan

United Healthcare

Other Insurance

No Insurance

ADDITIONAL FAMILY MEMBERS TO INCLUDE (IF ANY)

NAME \_\_\_\_\_

DOB \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

ADDITIONAL NOTES (OPTIONAL):

NOTIFICATION:

DO WE NEED TO GET BACK WITH REFERRAL SOURCE FOR ANY REASON?  YES  NO

If yes, a signed authorization to release health information must be included.

INTERNAL USE ONLY

FORWARDED TO \_\_\_\_\_ DATE \_\_\_\_\_

BY \_\_\_\_\_  IN WELLIGENT  IN AGENCY MAILBOX