

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
- SEVEN CHALLENGES
- 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

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PAYMENT INFORMATION

CLIENT HAS ACCEPTED PRIVATE INSURANCE?

CLIENT IS LEGAL U.S. RESIDENT? YES NO

Blue Cross & Blue Shield

CLIENT HAS MEDICAID: YES NO

Presbyterian Health Plan

IF YES: MEDICAID # _____

United Healthcare

CENTENNIAL HEALTHCARE # _____

Other Insurance

RECERTIFICATION DATE _____

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