Universal Referral Form -Enter as much Information as possible

PROVIDER

Date:_____

Please identify service(s) you are requesting:

CHILD SERVICES ☐ **ADULT SERVICES:** ☐

MH Assessment **Substance Abuse Assessment** **Out Patient treatment** **Psychiatric**

Client Information		
Name:		SSN:
DOB:	Sex:	Preferred Language:
Address:		
Phone:		Cell:
Caregiver Names:		Relationship:
Place of service: ☐ Family Home	☐ Provider office	☐ Other: _____
Medicaid # / Insurance Provider Name and #:		
Court ordered: ☐ yes ☐ no		
Presenting Problems		
Current:		
History:		
Current and Previous Therapeutic or Psychiatric services (if available):		

Current Medications:		
CBHA attached: ☐ yes ☐ no		
Parent/Legal Guardian (person able to consent for services)		
Name:	Phone:	Cell:
Address:		
Relationship to Patient:		
Email address:		
Court order attached: ☐ Shelter order ☐ Change of custody order ☐ Not applicable		
Referring Person		
Referring agency:		
Primary contact:	Phone:	Cell:
Address:		
Relationship to Patient:		
Email address:		
Signature:	Date:	