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Intake Referral Form

Please Print Clearly

Date of Referral: ______________________________

Consumer Information:

Consumer Name: ____

Type: ☐ No Insurance (Fee For Service) ☐Peachstate ☐Amerigroup ☐ Wellcare ☐Reg Medicaid

Medicaid #________________________**SS#**_____________________ **Date of Birth:** ______________

Age: _____ **Grade Level**:_________ **Gender:** ☐Male ☐Female **Race**: _____________________

Address: ______________________________**City**: _____________ **State**: _______ **Zip**: ___________

Home Phone#: _____________________ **Cell #:** _____________________ **Work #:** _______________

Parent/Guardian: ____

Referral Source Information:

Name & Title of Person making referral: ____

Agency: _______________________ **Court Mandated?** ☐**Yes or** ☐**No County:** ________________

Phone # of person making referral: ________________________ **Fax number:** _________________

Email address:____

Service(s) Requested:

☐ CORE (Individual, Family, and Skills 1-3 visits per week)
☐ Intensive Family Intervention (Family, Individual, and Skills 3-5 visits per week)
☐ Peer Support
☐ Psychiatric Evaluation and Treatment
☐ Psychological Testing

Reason For Referral:

Please check all that apply and provide brief description below:

☐ **History of Counseling** ☐ **Suicidal/Homicidal/Self-Harming** ☐ **Substance Abuse/Dependence**

☐ **Legal Involvement** ☐ **Out of Home Placement** ☐ **Hospitalizations** ☐ **Psychosis**

☐ **Medication Use** ☐ **History of Abuse/Trauma** ☐ **Risk/History of Homelessness**

☐ **DFCS involvement** ☐ **Psychological/Psychiatric Eval completed (please attach to referral)**

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Thank you for choosing Georgia Health Partners, LLC