

Georgia Health Partners, LLC

5255 Snapfinger Park Dr, Ste. 120 Decatur, GA 30035

Office: (678) 389-4856 Fax: (404) 393-7342 Email: referrals@gahealthpartners.com

INTAKE/REFERRAL FORM

Date of Referral:	
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INDIVIDUAL INFORMATION:

Individual Name:							
Insurance Type: <input type="checkbox"/> No Insurance <input type="checkbox"/> Amerigroup <input type="checkbox"/> Caresource <input type="checkbox"/> Medicaid <input type="checkbox"/> Peachstate <input type="checkbox"/> Wellcare <input type="checkbox"/> Undocumented							
Insurance #		SS#		Date of Birth:			
Age:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Race:		
Address:			City:		State:		Zip:
Parent/Guardian Name:							
Phone Number(s):							
Emergency Contact Name:							
Phone Number(s):							

REFERRAL SOURCE INFORMATION:

Name and Title of Person Making Referral:	
Agency/Organization:	
Referral Source Type:	<input type="checkbox"/> DFCS <input type="checkbox"/> FosterParent <input type="checkbox"/> MHProf <input type="checkbox"/> School <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> DJJ (County) _____ <input type="checkbox"/> Juv. Court (County) _____
Phone Number of Person Making Referral:	
Email Address of Person Making Referral(<i>required</i>):	
Is Individual Mandated to Participate in Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SERVICE(S) REQUESTED:

<input type="checkbox"/> CORE (Individual, Family, and Skills 1-3 visits per week)
<input type="checkbox"/> Intensive Family Intervention (Family, Individual, and Skills 3+ visits per week)
<input type="checkbox"/> Peer Support (Adults only)
<input type="checkbox"/> Psychiatric Evaluation and Treatment
<input type="checkbox"/> Psychological Testing

REASON FOR REFERRAL:

<input type="checkbox"/> History of Counseling <input type="checkbox"/> Suicidal/Homicidal/Self-Harming <input type="checkbox"/> Substance Abuse/Dependence <input type="checkbox"/> Legal Involvement
<input type="checkbox"/> Risk/History of Homelessness <input type="checkbox"/> Medication Use <input type="checkbox"/> Hospitalization <input type="checkbox"/> Psychosis <input type="checkbox"/> Out of Home Placement
<input type="checkbox"/> History of Abuse/Trauma <input type="checkbox"/> DFCS Involvement <input type="checkbox"/> Psychological/Psychiatric Eval completed (please attach to referral)
<input type="checkbox"/> Other:

FOR GHP OFFICE USE ONLY:

Date Referral Received: _____ Who Received Referral: _____

Insurance Verified: Medicaid Wellcare Amerigroup CaresourcePeachstate Peach Care for Kids Undocumented State Contacted

Insurance Status: Active Inactive Date of Referral Verification: _____ Spoke with: _____

Assessor Assigned: _____ Date Assigned: _____

Requested Assessor: _____ Requested Therapist: _____ Requested PP: _____