|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Referral: | |  | | | | | | | | | |
| Individual Name: | |  | | | | | | | | | |
| Insurance Type: | | Amerigroup  Caresource  Medicaid  Peachstate  Medicare | | | | | | | | | |
| Medicaid# |  | | SS# |  | | | Date of Birth: | |  | | |
| Age: |  | | Gender: |  | | | Race: | |  | | |
| Address: |  | | | | City: |  | State: |  | | Zip: |  |
| Parent/Guardian Name: | | | | | |  | | | | | |
| Parent/Guardian Phone Number(s): | | | | | |  | | | | | |
| Parent/Guardian Email Address: | | | | | |  | | | | | |
| Emergency Contact Name: | | | | | |  | | | | | |
| Emergency Contact Phone Number(s): | | | | | |  | | | | | |
| Has the individual consented to this referral being made? | | | | | | **YES  NO** | | | | | |
| Is individual/family open to telehealth services? | | | | | | **YES  NO** | | | | | |
| Is a translator/interpreter needed for services? | | | | | | **YES  NO** | | | | | |
| Is the individual currently receiving counseling services? | | | | | | **YES  NO**  **If YES, name of service provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

**REFERRAL SOURCE INFORMATION:**

|  |  |
| --- | --- |
| Name and title of person making referral: |  |
| Agency/Organization: |  |
| Referral source type: | DFCS Foster Parent MH Prof School Parent Self  Juvenile Court/Justice  Hospital  Counseling Agency |
| Phone number of person making referral: |  |
| Email address of person making referral: |  |
| Is individual mandated to participate in services? | **YES  NO** |

**SERVICE(S) REQUESTED:**

|  |
| --- |
| Non-Intensive Outpatient Services (Individual, Family, and Skills 1-3 visits per week) |
| Peer Support (Adults only) |
| Psychiatric Evaluation and Treatment/ Medication Management |

**REASON FOR REFERRAL:**

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