Georgia Health Partners, LLC

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INTAKE/REFERRAL FORM

Date of Referral:	

INDIVIDUAL INFORMATION:

Individual Name:							
Insurance Type:	☐ Amerigroup ☐ Caresource ☐ Medicaid ☐ Peachstate						
Medicaid#		SS#		Date of Birth:			
Age:		Gender:	☐ Male ☐ Female	Race:			
Address:		City:		State:		Zip:	

Parent/Guardian Name:	
Phone Number(s):	
Emergency Contact Name:	
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)
- ☐ Intensive Family Intervention (Family, Individual, and Skills 3+ visits per week)
- ☐ Peer Support (Adults only)
- ☐ Psychiatric Evaluation and Treatment

REASON FOR REFERRAL:

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