|  |  |
| --- | --- |
| 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:  |