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| **REFERRAL / REQUEST FOR SERVICES** |
| **CLIENT INFORMATION** |
| **MEDICAID#** |  | [ ]  CMS  [ ]  Staywell [ ]  Full Medicaid/Medicare |
| **FIRST NAME** |  | **LAST NAME** |  |
| **DATE OF BIRTH** |  | **AGE** |  | **GENDER** |  |
| **PREFERRED LANGUAGE** |  | **ETHNICITY** |  |
| **ADDRESS** |  | **APT#** |  |
| **CITY** |  | **STATE** |  | **ZIP CODE** |  |
| **LEGAL GUARDIAN** |  | **RELATIONSHIP** |  |
| **TELEPHONE #** |  | **EMAIL:** |  |
| **REASON FOR SERVICES: (DIAGNOSIS, SYMPTOMS ETC)** |  |
| **PSYCHIATRIC PROVIDER?** |  | **THERAPIST?****PSR?**  |  |
| **AREAS OF CONCERN** | [ ]  | Physical Aggression | [ ]  | Tantrums | [ ]  | Noncompliance | [ ]  | Truancy |
| [ ]  | Verbal Aggression | [ ]  | Stealing | [ ]  | Lying | [ ]  | Anxiety |
| [ ]  | Property Destruction | [ ]  | Depression | [ ]  | Low-self esteem | [ ]  | Impulsive |
| [ ]  | Sleeping problems | [ ]  | Eating problems | [ ]  | Hyperactive | [ ]  | Social Skills/Peer relations |
| [ ]  | Suicidal Ideations | [ ]  | Homicidal Ideation | [ ]  | Substance abuse | [ ]  | Parenting issues |
| [ ]  | Educational Issues | [ ]  | Medical needs | [ ]  | Food, clothing, financial needs | [ ]  | Legal Needs |
| [ ]  | Other: |  |
| **BAKER ACT WITHIN LAST 12 MONTHS?** | **[ ]  Yes [ ]  No**  |
| **ARE SERVICES MANDATED BY COURT ORDER?** | **[ ]  Yes [ ]  No**  |
| **PROVIDER REQUESTED?** |  |
| **REFERRAL SOURCE:** |
| **NAME:** |  | **CONTACT #:** |  |
| **COMPANY:** |  | **FAX:** |  |
| **EMAIL:** |  |
| **OFFICE USE ONLY** |
| **ASSIGNED TO:** |  |
| **REFERRED OUT TO:** |  |
| **SIGNATURE OF SUPERVISOR:**  |  |