|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | |  | | | | | | | | | | | | | | | | | | | | | | |