Referral Form

Demographic Information (Print)

Name: _____Age _____ Date of Birth _____SSN:_____ Race:_____

Address:_____ City_____ State_____ Zip code_____ County:_____

Home Number:_____ Emergency Contact _____Number_____

Minor: O Yes O No If Yes Name of Parent/Guardian:_____ Contact Number:_____

Insurance and Medical Information (Print)

Name of Insurance: _____ Number:_____ Physician's Name: _____

Contact Number:_____ Current Medications:_____ _____

Prescribing Physician:_____

Education Information (If currently enrolled) (Print):

Consumer's School: _____Current Grade:_____

Special Academic Needs: O No O Yes, If yes, explain _____

Behavioral Health (Print)

Currently Receiving Behavioral/Mental Health Services: Yes O No O Unknown O
If yes, Type _____

Past History of Behavioral/Mental Health Services: Yes O No O Unknown O
If yes, Type_____

Reason for Referral

Academic Problems O Court Involvement O Criminal Charges O Violence O
Consumer Issues O Family Concerns O Social Hx drugs O Anger Management O Community Problems (behaviors) O Drug Abuse O Family Hx drugs O Medical Hx O
Psychiatric Hx O

Person Referring Name (Print) _____ Signature: _____ Referral Date: _____

Referral Response: _____

Respondent's Name (Print) _____Signature: _____ Date:_____

Revised 2/2012