Logo, company name

Description automatically generated

**Referral Form**

**Client information**

Client name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age :\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current problems in services**

Presenting problems/Risk conditions qualified the individual for Services:

**See reason for referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Is there any current service is being offered ? Yes or No?**

**Has psychosocial rehabilitation services been received before or any other mental health service? Yes no if yes, when were services ended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eligibility in documentation ( one of these must include in order to be eligible for services )**

**client meets at least two of the following criteria on a regular or intermediate basis**

1. Has difficulty establishing maintaining normal personal relationships in such a degree that he or she is at risk of hospitalization or out of home placement because of conflicts with the family or community.
2. Exhibit such a inappropriate behavior that repeated interventions by the mental health, social service, or judicial system is necessary
3. exhibits difficulty in cognitive ability such that he or she is unable to recognize personal danger or recognize significant inappropriate social behavior**.**

**Client must meet at least one of the following**

1. The client requires services that are far more extensive than out patient care to stabilize the client in family situation
2. The client's residence as the setting for service is more likely to be successful than a clinic.
3. Client is enrolled in Medicaid

**Please include the following**

1. social history (any background/social history available on client)
2. copy of Medicaid card, if available
3. relevant testing documents if available (i.e, IEP, psychological, etc

**Person making the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**agency :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date :\_\_\_\_\_\_\_\_\_\_\_\_\_**