|  |  |  |  |  |  |  |  |  |
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| Date of Referral: |  |  | Time of Referral: |  |  | Client #: |  |  |

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| **Please indicate which support group this referral is for:** | | |
| Perinatal Mental Health | Youth Grief | COVID Peer Support |
| Teen Pregnancy | Parents of Addicted Youth | Parenting |
| Adult Grief | Adult Domestic Violence | Divorce |
| Life Over Matter/Life Workshop | Domestic Violence Offender | Other: |

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| **(Office Use Only)** | **Assigned To:** | | Date Assigned: |
| Intake Date: | | Date of First Contact: | |

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| **Client/Family Name:** | | DOB: | | Gender: |
| Name of Caretaker | | Relationship to Client/Family: | | |
| Emergency Contact: | | Emergency Contact Phone No: | | |
| If child is a minor, who has legal and physical custody: | | | | |
| Counselor Preference: Female Male Either | | Email Address: | | |
| Address: | | | | |
| Preferred Phone No: | | Back up/Alternative Phone #: | | |
| Primary Language: | Interpreter? Yes No | | Scheduling needs: | |
| Nationality (Country of Origin): | | Race: | | |
| School: | | Health Center/PCP: | | |

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| **Referral Source Name:** | | Role with Family/Agency: |
| Phone: | Fax No: | Email Address: |

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| **Insurance Information:** | | | | | **If No Insurance ID, Social Security Number:** | | | | | | | | | |
| Primary Insurance Plan: | | |  | | | | | |  | Insurance ID #: | |  | | |
| Secondary Insurance Plan: | | | |  | | | | |  | Insurance ID #: | |  | | |
| MMIS #: |  | | | | | | | |  | Auth Approval #: | |  | | |
| Date Authorization Submitted: | | | | | |  | | |  | Date Authorization Approved: | | | |  |
| Auth Start Date: | |  |  | Auth End Date: | | | |  |  |  | Units Approved: | |  | |
| Axis 1 (Current Diagnosis Dx Code(s): | | | | | | |  | | | | | | | |
| Who generated diagnosis and when? | | | | | | |  | | | | | | | |

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| What are the current concerns or behaviors for the individual/family member (Patient) that led to the referral? |
|  |
| What has been helpful for the individual/family (Patient) currently or in the past? What are their strengths? |
|  |