|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: |

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

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

|  |  |
| --- | --- |
| **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? |  |

|  |
| --- |
| 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? |
|  |