REFERRAL SCREENING FORM

Client Information

Client's Name: ____ DOB: ______________________

SS#: _________________________________ Insurance ID: ______________________________

Address: ____ City: ________________________ State: ___________

Phone: _______________________________________ Cell Phone: _______________________________________

Caretaker Name or Emergency Contact: ___________________________________

Daytime Phone: _________________________________

Relationship to the Client: Parent ☐ / Foster Parent ☐ / Legal Guardian ☐ / Social Worker ☐ / Case Manager ☐ / Other ___________________________

☐ Married ☐ Single ☐ Divorced ☐ Male ☐ Female ☐ If female, are you currently pregnant?

Have you been a patient at an inpatient facility within the past 30 days? ______________

Any arrests in the past 30 days? _____________

Are you employed? ______________

What is your highest grade level completed? _____________

Any known current medical or psychiatric diagnoses: ____

Any current medications? ____

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Primary Care Provider: ____

Reason(s) for Referral (check all that apply)		
☐ Therapy/Counseling	☐ Diagnostic Evaluation	☐ PRP
☐ Psychiatric Evaluation	☐ Court Involvement	☐ Discharge from inpatient facility
☐ Other______________________		

Payment Information

☐ Medicaid ☐ Medicare ☐ Medicaid/Medicare ☐ Private Insurance ☐ Self Pay

Staff Signature: ____ Date: ______________________

If referral is another agency, please complete this section.

Referral Source: ____ Agency: ____________________________

Address: _______________________________________ State: _________ Phone: ______________________

Revised 9/16 DJM