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| **Date:** |  | | | | | | | | | | | **Patient Intake / Referral Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Mode:** | | | | | | |  |
| **Legal Name:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Gender:** | | | | | | | | | | M  F | | | | | | | | | | | | | | | | | **DOB**: | | | | | | |  | | | | | | |
| **Insurance #:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Type:** | | | | |  | | | | | | | | | | | **SS #:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent/\*Guardian\*:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Relationship:** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Address:** | | | | |  | | | | | | | | | | | | | | | | | **Apt/Unit #:** | | | | | | | | |  | | | | | | | **City:** | | | | | | |  | | | | | | | | | | | | | | **ST:** | | | | | | |  | | | | | | | | **Zip:** | | | | | | |  | | |
| **Phone #:** | | | | |  | | | | | | | | | | | | | | | | **Alt.** #: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **Emrg. #:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Email:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Ethnicity:** | | | | | | | | | | |  | | | | | | | | | **Primary Language:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| **Medical / Psychiatric History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Previous Psychiatrist:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact Info:** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Current Medications:** | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Compliant**: | | | | | | | | | | | | | | | Yes  No | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | **Prescribed By:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **# Hospitalizations:** | | | | | | | | |  | | | | | | **Last Date/Extent:** | | | | | | | | |  | | | | | | | | | | | | | | | **Self-Mutilation:** | | | | | | | | | | | | Y  N | | | | | | | | | | | | | | | | | **Last Time:** | | | | | | | | | | |  | | | | |
| **Suicidal Ideation:** | | | | | | | | | Y  N | | | | | | | | | **Last Ideation:** | | | | | | | | | |  | | | | | | | | | | | | | | **Attempts:** | | | | | | | | Y  N | | | | | | | | | | | | | | | | | **Last Attempt:** | | | | | | | | | | | | | | |  | |
| **History of Substance Use:** | | | | | | | | | Y  N | | | | | | | **Date of Last Use:** | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | **Frequency:** | | | | | | | | | | | | | | | | | Daily  Weekly  Monthly  Rarely  Socially  Never | | | | | | | | | | | | | | | | |
| **Substance(s) of Choice:** | | | | | | | | | | | | |
| **Any Other Health Conditions:** | | | | | | | | | | | | | | Yes  No | | | | | **Explain:** | | | | | | **For Example: Hypertension, Diabetes, High Blood Pressure, Seizures, etc.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Chief Complaint…**  ***\*REFERRAL IS INCOMPLETE W/O THIS SECTION COMPLETED\**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Brief History /**  **Presenting Problem(s) / Current Diagnosis:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referred By:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact Info:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Administrative Comments:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Assessment Scheduled Date:** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **Assessing Clinician**: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*\* REFERRAL is COMPLETE; unless the referral source is**  **DFCS, Court, DJJ, or Mental Health Agencies; please continue \*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*\* DFCS/Foster Care, Court/DJJ or Mental Health Hospital, PLEASE Complete Part 2 of Referral Form \*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Department of Family & Children Services Case**  Yes  No  ***\* PLEASE submit/attach supporting documents (i.e. completed CCFA, Trauma Assessment, Psychological, etc.) \**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **County:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Supporting Documentation Attached:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | |
| **Case Mgr Name:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | **Phone #:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **Fax #:** | | | | | | | | |  | | | | | | | | | | | |
| **Case Mgr Email:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **Supervisor’s Name:** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Placement Information (if other than Biological Parent or Legal Guardian)**  ***\* Please submit/attach copy of Guardianship/Placement Agreement \**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name or Agency:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact #:** | | | | | | | | | | | | | | |  | | | | | | | | |
| **Address:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **City:** | | | | | | | |  | | | | | | | | | | | | **State:** | | | | | | | | | | | |  | | | | | | | **Zip:** | | | | | | | | |  | | | |
| **Type:** | | Group Home Foster Home Temp Housing Extended Housing Non-Relative (Fictive Kin.)  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Court Ordered (Drug Court, Dept. Juvenile Justice, etc.)**  Yes  No  ***\* PLEASE submit/attach supporting documents (i.e. completed CCFA, court recommendations, probation order, etc.) \**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **County:** | |  | | | | | | | | | | | **Supporting Documentation Attached:** | | | | | | | | | | | | | Yes  No | | | |
| **Probation Officer Name:** | | | | |  | | | | | | | | | **Phone #:** | | |  | | | | | | | **Fax #:** | | |  | | |
| **Probation Officer Email:** | | | | |  | | | | | | | | | **Supervisor’s Name:** | | | | | |  | | | | | | | | | |
| **Presenting Charge/Offense:** | | | | | |  | | | | | | | | | | | | | **Next Court Date:** | | | | | | | |  | |
| **Mental/Behavioral Health Hospital Referral**  Yes  No  ***\* PLEASE submit/attach supporting documents (i.e. admission paperwork, dis. summary, last progress note, etc.) \**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Facility:** | |  | | | | | | | | | **Phone:** | | |  | | | | | | | | **Fax:** | |  | | | | |
| **Admission Date:** | |  | | | | | **Discharge (Anticipated) Date:** | | | | | | | |  | | | | | | |  | | | | | | |
| **Presenting Problems at Time of Admission:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Discharging Therapist:** | | |  | | | | | | | **Direct Contact #:** | | | | | | |  | | | | | | | | | | | |
| **Medications Prescribed**  None | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | **Dosage** | | | **Prescribed By** | | | | | | | | | | | **Reason** | | | | | | | | |
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| **Discharging Mental Health Diagnosis(es)**  None | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis:** | | | | | | | | **Diagnosed By & Date:** | | | | | | | | | | | | | **Historic Diagnosis:** | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | ☐ Yes ☐ No | | | | | |
| ***\* Please provide/submit any documentation supporting the above diagnosis(es) \**** | | | | | | | | | | | | | | | | | | | | | | | | | | |