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

|  |
| --- |
| **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** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **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) \**** |