Referral Form

Date of Referral:

Name of Caller:		Telephone #: Email address:		
Client's Current Guardian:		Referral Source: (School, DFCS, Parent, Hospital):		
Consumer Name: Last First MI		Other Names:		Sex: Ethnicity:
Address	City	State	Zip Code	County
Telephone (Home/Cell/Work)	SS#	DOB	Legal Guardian/Parent	Telephone #

Medical Coverage: Check all that apply.

Medicaid #	PeachCare#	CMO#	Private Insurance	Other	None
		○ Amerigroup ○ PeachState/Cenpatico ○ Wellcare/Magellan			

Service Requested/Service Triage:

_____ (TFCBT) Trauma-Focused Cognitive Behavior Therapy
_____ (CCFA) Comprehensive Child and Family Assessment
_____ Wrap Around Services
_____ Group Counseling
_____ Family Counseling
_____ Family Support Services
_____ Career Development/Readiness
_____ Mentoring
_____ Behavioral Assistance
_____ Individual Counseling
_____ Couples Counseling
_____ Mental Health Assessment
_____ CSI Support Services
_____ Other: _____

1. Presenting Problem (Include grief issues)

2. History of Presenting Problem

3. Current Medical Problems

4. Current Medications (include dosage)

5. History of Prior Psychiatric/Substance Abuse Treatment within past 3 years and response to treatment
*****If recent psychological evaluation available (within one year), please submit copy**

Problem/Diagnosis	Dates	Type of Treatment, Provider, Location	Inpatient or Outpatient

Response to Treatment (report any progress made)

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