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| GENERAL INFORMATION: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LAST NAME:** |  | | | | | | **FIRST:** | | |  | | | | | **AGE:** |  | | | **DOB:** | |  | | | **GENDER:** | **M F** |
| **ADDRESS:** |  | | | | | | | | | | | | | | | | | | | | **PHONE:** | |  | | |
| **CITY:** |  | | | | | | | | | | **ZIP:** | |  | | | | **COUNTY:**  **PHONE:** | | |  | | | | | |
| **PRIMARY LANGUAGE:** | | | | |  | | | | | | | | | **SECONDARY:** | | |  | | | | | | | | |
| **MEDICAID/MEDICARE:** | **YES NO** | | | | | **MEDICAID/MEDICARE/ HMO Number:** | | | | | | |  | | | | | | | | **SS #:** |  | | | |
| **OTHER INSURANCE:** | | | | **YES NO** | | | | | | **INSURED:** | | |  | | | | | | | | **Policy Number:** | |  | | |
| **DIAGNOSIS:** |  | | | | | | | | | | | | | | | | **PHYSICIAN:** | | | |  | | | | |
| **MEDICATION(S):** | | |  | | | | | | | | | | | | | | **COMPLIANT:** | | | | **YES NO** | | | | |
| **SPECIAL PHYSICAL/ACADEMIC NEEDS:** | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **DCF INVOLVEMENT:** | | | **YES NO** | | | | | | **TYPE:** | | |  | | | | | | **STATUS:** | | |  | | | | |
| **LEGAL INVOLVEMENT:** | | | **YES NO** | | | | | | **TYPE:** | | | **DJJ OTHER** | | | | | | | | | | | | | |
| **(FOR MINOR CLIENT)**  **PARENT/GUARDIAN:** | | | |  | | | | | | | | | | | | | **CONTACT**  **INFORMATION:** | | | |  | | | | |
| reason for referral: | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please Provide A Brief Description Of Past Attempts To Assist This Client/Family: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral is currently receiving services from:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| THANK YOU FOR YOUR REFERRAL. PLEASE PROVIDE US WITH YOUR CONTACT INFORMATION AND/OR AN ALTERNATIVE CONTACT IN THE EVENT THAT WE REQUIRE ADDITIONAL INFORMATION. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| REFERRED BY (SIGNATURE) | |  | | | | | | | | | | | | | | | | DATE: | | |  | | | | |
| REFERRED BY (PRINT) | |  | | | | | | | | | | | | | | | | PHONE: | | |  | | | | |

**DO NOT WRITE BELOW**

|  |  |  |
| --- | --- | --- |
| **FOR OFFICE USE** | | |
| CLIENT #: | REFERRAL RECEIVED  DATE BY | REFERRAL ASSIGNMENT  DATE TO TCM/THERAPIST/PSR |
|  |  |  |