Intake Referral Form

Date of Referral: ___________________

SECTION 1: Client Information ▢ **Self Referral** ▢ **Agency Referral**

Client Name: _________________________________ DOB/Age:_________________
Social Security#: ______________ Highest Grade/Education Completed:__________
Male ___ Female ____

If Minor: Where Does the child currently reside? Both Parents___ Mom___ Dad___ Other___
Parent/Guardian Name:____
Email:____
Home ph#: _______________________________ Cell ph#:_____________________________________
Leave Messages: Yes___ No___

Physical Address:____

Emergency Contact (name/ph#): ____

Presenting Problem(s):
____
____

Current ICD-10 Diagnosis(es):
Primary:_______ Secondary: _______ Tertiary:_______ Other:_______

Has the child/family received therapeutic/mental health services before? If so, when, where, and what was the diagnosis/outcome? ____
____

SECTION 2: Available Services (Medical Necessity will be determined by Diagnostic Assessment)

▢ Individual Therapy ▢ Group Therapy ▢ Family Therapy
▢ Crisis Management
▢ Behavior Modification ▢ Family Support Services ▢ Psychosocial Rehab Services
▢ Diagnostic Assessment:
▢ Other: ____

SECTION 3: Insurance Information

Type of Insurance: Private pay___ Medicare___ Medicaid___ EAP___ Other___
Insurance Name:________________________
Policy/Member ID: ______________________Group #:___________

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Primary Card Holder's Name:____
Date of Birth:_____________________ Social Security Number:________________________
Relationship to Primary Card Holder: Self___ Spouse___ Child___ Other___

SECTION 4: Referring Agency Information

Referring Agency Name: ____
Referring Case Manager Name: ___________________________________ Referring Case Manager
Email: ___________________________________
Address:____
____
Phone#: ______________________________________ Fax#: ___________________________

SECTION 5: To be Completed by Intake Coordinator:
Will a diagnostic assessment be required?
What services would benefit the family/client?
What region does this referral belong to?
If this is a family/self referral; is the family working with any other agency?
When is/are the service(s) expected to start?
Worker preferences (age/sex/race/etc.)?

*Please attach any of the following you may have available:

▢ CCA/DA (assessment) ▢ Psychological Evaluation/ Diagnostic Assessment

▢ CALOCUS ▢ Psychiatric Evaluation ▢ IEP

For Office Use Only↓

First Appointment Date/Time:________________ Therapist Assigned______________________
Interviewer's Initials:_______ Welcome Letter sent? Yes__ No__ When?_____________

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