

General Referral for Services

Demographic Information:

Client Name:		Date of Birth:	Click or tap to enter a date.	Age:
Address:				
Current Phone #:	Is it ok to text appoint info: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Address:	Is it ok to email appointment info <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Carrier Name:				
Insurance/MA #:				

Children/Youth Only:

Parent/Guardian Name:	
Address:	
Current Phone #:	
Email Address:	

Primary Care Information: Does not have a Primary Care Physician currently

Physician Name:	
Address:	
Phone #:	

Services Requested:

<input type="checkbox"/>	Substance Abuse Assessment Only	<input type="checkbox"/>	Residential Treatment	<input type="checkbox"/>	Medication Management Only
<input type="checkbox"/>	Outpatient Mental Health Services	<input type="checkbox"/>	Early Intervention	<input type="checkbox"/>	Substance Abuse Services
<input type="checkbox"/>	DUI/DWI	<input type="checkbox"/>	Anger Management	<input type="checkbox"/>	Other:

Uninsured Clients Only:

If an individual does NOT have medical assistance/Medicaid, he or she must meet one or more of the following criteria to qualify for services through Uninsured Eligibility Coverage:

<input type="checkbox"/>	Currently homeless or at risk for homelessness
<input type="checkbox"/>	Has had an inpatient hospitalization within the last three (3) months
<input type="checkbox"/>	Has been incarcerated within the last three (3) months

Reason for Referral/Current Symptoms:

Mental Health Diagnosis: (Please list the ICD-10 codes)

Past Psychiatric or Substance Abuse Treatment:

Current Medication: Not currently using medication

Name of Medication	Dose	Frequency

Referral Source Signature: _____ Date: _____

For Program Use Only:

Type of Referral: Routine Crisis/Emergency

Date of Receipt: _____ Date of 1st Appointment/Assessment: _____

Date Client Notified of Appointment: _____ Date Consent Sent Out: _____

Did Individual Meet Medical Necessity Criteria? Yes No if No, was a referral provided to other provider? Yes No

Assigned Clinician: _____

Insurance Verification: Was the insurance verified? Yes No If no, date reached out to client: _____

Authorization to Release Information Signed: Yes No

