
# Referral Form

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**Date of Referral:** _____

## Individual Information:

**Individual Name**: _____

**Type**: ☐ No Insurance (Self-Pay) ☐ Peachstate ☐ Amerigroup ☐ Wellcare ☐ Caresource ☐ Other: _____

**Medicaid #**_____**SS#**_____ **Date of Birth:** _____

**Age**: _____ **Grade Level**:_____ **Gender:** ☐Male ☐Female **Race**: _____

**Address**: _____**City**: _____ **State**: _____ **Zip**: _____

**Home Phone#:** _____ **Cell #:** _____ **Work #:** _____

**Parent/Guardian**: _____

## Referral Source Information:

**Name & Title of Person making referral:** _____

**Agency:** _____ **Court Mandated?** ☐ **Yes or** ☐ **No** **County:** _____

**Phone # of person making referral:** _____ **Fax number:** _____

**Email address:**_____

## Service(s) Requested:

☐ Individual Counseling
☐ Family/Marriage/Couple Counseling
☐ Life Skills/Personal Development

**DOES THE INDIVIDUAL CURRENTLY RECEIVE COUNSELING SERVICES?** ☐ **YES** ☐ **NO**

**If so, what agency/type of services are provided?** _____

## Reason for Referral:

*Please check all that apply and provide brief description below:*

☐ **History of Counseling** ☐ **Suicidal/Homicidal/Self-Harming** ☐ **Substance Abuse/Dependence**

☐ **Legal Involvement** ☐ **Out of Home Placement** ☐ **Hospitalizations** ☐ **Psychosis**

☐ **History of Abuse/Trauma** ☐ **Risk/History of Homelessness** ☐ **Other**_____

☐ **DFCS involvement** ☐ **Psychological/Psychiatric Eval. completed (please attach to referral)**

*For Office Use Only* **Referral Received Date:** _____

**Ins. Type:** ☐Medicaid ☐Private **Ins. Status:** Active Inactive

**Spoke with:** _____ **Date:** _____