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| --- | --- |
| **Referring Person** | |
| **Name:** | **Date of Referral:** |
| **Agency:** | **Phone:** |
| **Contact Information (address, email, fax, etc.):** | |
| **Client Information** | |
| **Client Name:** | **DOB:** |
| **Parent/Guardian Name/Relationship:** | **Emergency Contact Name/Number:** |
| **Address, including County:** | **School Name:** |
| **Phone:** | **Grade Level:** |
| **Insurance Information** | |
| **Does the client have insurance and/or Medicaid?  Yes  No**  If YES, please provide the following information: | |
| **Primary Insurance Company:** | **Secondary Insurance Company:** |
| **Member’s Name:** | **Member’s Name:** |
| **Member’s DOB:** | **Member’s DOB:** |
| **Member’s SSN:** | **Member’s SSN:** |
| **Relationship to Client:** | **Relationship to Client:** |
| **ID #:** | **ID #:** |
| **Group #:** | **Group #:** |
| **Clinical Information** | |
| **Reason for referral:** | |
| **Diagnosis, if known** (include mental health & physical diagnoses and diagnosing provider, if possible): | |
| **Behaviors:**  Aggression  Property Destruction  Self-Injurious Behavior  Defiance  School Problems  Sexual Issues/Acting Out  Suicidal Thoughts/Actions  Homicidal Thoughts/Actions  Drug Use  AWOL/Truancy | **Other Behaviors/Additional Information:** |
| **Past Services** (In-Home Therapy/Case Management, Outpatient Therapy, Psychiatry, OT/PT/Speech): | |
| **Out of Home Placements** (include type of placement [relative, foster care, etc.] & dates when possible): | |
| **Past/Current CPS Involvement** (include worker name and number, if available): | |
| **Is client currently taking any medication?  Yes  No** If YES, please provide the following information:  Name of Medication Dosage/Frequency Name of Prescribing Doctor Reason for Medication  1.  2.  3.  4.  5. | |
|  | |
| **Requesting TCM Services?  Yes  No**  **Requesting Therapy Services?  Yes  No** | **Request for Specific TCM/Therapist:** |