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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 Medication1.2.3.4.5. |
|  |
| **Requesting TCM Services?** [ ]  **Yes** [ ]  **No** **Requesting Therapy Services?** [ ]  **Yes** [ ]  **No**  | **Request for Specific TCM/Therapist:** |