Referral Application Form

Patient Demographic Information		
Full Name: Preferred Name, if different:	Primary Contact Number:	
Age: DOB: Race:	Marital Status: □Single □Married □Divorced/Separated □Widowed	
Insurance: ☐Private ☐Medicaid ☐Self Pay ☐Medicare	ID/ Policy Number:	
Social Sec #:	Place of Birth:	
Height: Weight:	Distinguishing Marks:	
Primary Language: Religion: □Male □Female □Other/ Do not wish to disclose	Allergies: Medical Conditions: DSM Diagnosis:	
Physical Address:	City:	Zip:
Mailing Address, *if different*:	City:	Zip:

Referral Information

Please tell us your reason for Referral/ Presenting Problems:

Referred by : ☐Self ☐Healthcare Provider ☐Community Agency *(i.e: Social Services, DJJ, MCO/LME, School)* ☐Other

Accommodations:

Are there any learning or communication barriers to be aware of or needs to accommodate: ☐Yes ☐No

Details:

☐Assessed, None to Report

Safety Risks *This section is required. **(Describe environmental and behavioral safety concerns identified for potential service recipient and/or staff)**
Include risk related to detox, suicide, and/or homicide safety risks

☐Assessed, None to Report

Emergency Contact Information

Name:	
Physical Address:	Primary Phone:
Mailing Address, *if different*:	Secondary Phone:
☐Under 18 or Other Legally Responsible Party (LRP) identified**	
LRP Full Name:	Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other
LRP Address *if different*:	Primary Contact Number:

Physician Information

Physician Name	Specialty	Address	Telephone Number	Last Date Seen

Brief Medical History:

Current School	Grade Level

Pertinent Medical Issues:

Cultural Consideration: