|  |
| --- |
| **REFERRAL SOURCE** |
| **AGENCY** |       | **PHONE** |       |
| **Person Completing** |       | **EMAIL** |       |
|  **CLIENT INFORMATION** |
| **LAST NAME** |       | **FIRST NAME**  |       |
| **DATE OF BIRTH** |       | **GENDER** |       |
| **SOCIAL SECURITY #** |       | **MEDICAID #** |       |
| **Race** |       | **LANGUAGE REQUIRED** |       |
| **GUARDIAN NAME** |       | **GUARDIAN RELATIONSHIP** |       |
| **CLIENT’S ADDRESS** |       | **CELL PHONE** |       |
|       | **HOME PHONE** |       |
|       | **WORK PHONE** |       |
|       | **EMAIL** |       |
| **Insurance Type** | [ ]  Medicaid [ ]  Self Pay [ ] Other:       |
| **Insurance ID#** |       | **Insurance Name:** |       |
| **Name of School/Employer** |       | **Insurance Phone #** |       |
| **PRESENTING CONCERNS COMMENTS** Attach **/** additional sheets and / or supporting documentation as deemed necessary. |
| **REASON FOR REFERRAL** | [ ] Physical Aggression [ ] Runaway [ ] Tantrums [ ] Lying [ ] Verbal Aggression [ ] Property Destruction [ ] Truancy [ ] Sexually Acting Out [ ] Non-Compliance [ ] Disruptive Behavior [ ] Stealing [ ] Self-Injury/Suicidal [ ] Language delayed [ ] Developmental disability [ ] Autistic/ASD [ ] Alcohol/Drug Problem [ ] Depression [ ] Anxiety [ ] Self Care [ ] Toileting**Other:**       |
| **PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.**       |
| **SERVICE / SPECIALTY REQUESTED** | [ ]  **Behavior Analysis** [ ]  **Counseling** |
| **ADDITIONAL COMMENTS** |       |
| **For Admin Use Only** |
| **AUTHORIZATION REQUIRED?** |  [ ]  | **YES** | [ ]  | **NO** | **AUTH #** |       | **# OF VISITS** |       | **AUTH EXP. DATE** |       |
| **Copay / Auth Notes** |       |
| **Assigned to:** |       |
| **Date Received:** |       | **Date Assigned:** |       |