

INTERCEPT HEALTH

Raising Our children
REFERRAL FORM

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| **Identifying Information** |

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| Referral Date: | DOB: |
| Parent Name: | SS#: |
| Address:

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  | Race: |
| Parent/Legal Guardian: | Phone:  |
| Referring Agent: | Phone: |
| Address:  | E-Mail: |

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| **Funding Information**  |

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| CSA/Grant:   | Service Dates: |
| Units Hours Approved: | Date Verified: |

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| **Clinical Screening**  |

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| Danger to Self/Others  | Hospitalization Hx | Depression/Sadness |
| Physical Aggression | Outpatient Tx  | Legal Involvement |
| Sexually Inappropriate | Suicide Attempts | Bereavement Issues |
| DSS Involvement | Client Substance Abuse | Victim Physical/Emotional Abuse  |
| Parent/Child Problems | Eating/Sleeping Disturbance | Victim Sexual Abuse/Molestation  |
| Marital Discord | Anxiety/Phobias | Other: |

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| Reason for Referral: |
| Referrals to Other Services/Further Assessments: |

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| **If available, please provide copies of:**  |

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|  Social History  |  Psychological Evaluation  | Legal History  | Current Physical Exam  |

  Prescreen Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  IH Staff/Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_