INTERCEPT HEALTH
Referral Form

Please send completed referrals to **refer@interceptthealth.com**

Identifying Information			
Referral Date:		Parent Contacted:	
Client:		Date of Birth:	SSN:
Phone:	Gender:	Race:	Marital Status:
Client Address:			
Parent/Guardian:		Phone:	
Current Address:			
School:	Grade:	Special Education:	
Case Manager:		DSS Case Worker: (if applicable)	
Primary Physician:		Other Professionals Involved:	
Psychiatrist (if applicable):			
Medication/ Dosage (if applicable):			

Insurance/Medicaid Information	
Private Insurance Plan #	Provider:
Medicaid Recipient # (12 digit):	Recipient Eligible:
CCC Plus: Yes No	Provider:

Clinical Screening		
☐ Danger to Self/Others (Explain below)	☐ Hospitalization Hx - #	☐ Legal Involvement
☐ Physical Aggression	☐ Outpatient Tx	☐ Runaway Potential
☐ Sexually Inappropriate	☐ Suicide Attempts - #	☐ Chronic Medical Issues
☐ Peer-Relationship Problems	☐ Child Substance Abuse	☐ Victim Physical/Emotional Abuse
☐ Parent-Child Problems	☐ Eating/Sleeping Disturbance	☐ Victim Sexual Abuse
☐ School Failure/Behavior Problems	☐ Anxiety/Phobias	☐ Death/Loss Issues
☐ Truancy/Drop Out/Expulsion	☐ Sadness/Depression	☐ Foster Placement

Service Requested &
Reason for Referral:

Referral Source Name: **Referral Source E-Mail:**

If available, please provide:			
☐ Social History	☐ Current Psychological	☐ Legal History	☐ Current Physical Exam

Pre-screen Completed By: Date:

IH Clinical Supervisor/Reviewer: Date:

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