Referral/Intake Form

Patient: _____ **Age:** _____ **D.O.B.:** _____

Social Security Number: _____

Address: _____ **City:** _____ **Zip:**_____
Mobile/Home phone number: _____

Email:_____

Patient Parents/Guardians Name (if applicable):_____

Address: _____ **City:** _____ **Zip:**_____
Mobile/Home phone number: _____

Email:_____

TPL Primary Insurance: YES or NO

Insurance Company: _____
Policy #:_____
Primary Holder Name:_____
TPL Billing Address: _____
TPL Phone #_____
Member ID #: _____

Medicaid Primary Insurance: YES or NO

Managed Care Organization: _____
Member #_____
Medicaid ID #_____
Start Date_____

Referral Source Contact:_____
County: _____ **Phone number:** _____**Email:** _____
Desired Goal/Desired Results: _____

Reason for Referral (Please Explain Neglect/Abuse/Medical/Legal Issues/Existing MH or SUD Diagnosis):

_____
_____
_____