General Referral Form

Date of Referral: ______________

Referring Agency:__________________________**Phone#:**______________________**Contact:** ________________

Email of contact: _________________________________

How did you hear about us? ____________________________

Name:___________________________________DOB:______________SS#:_______________________________

Parent/Legal Guardian Name:_______________________ Gender: M / F / O Marital Status:_____________

Address:____Contact Phone #: ____________________________

Email:____________________________Emergency Contact: (Name/Phone) __________________________________

Insurance:______________________________

Medicaid

MA#___________________________

QMB is Medicare -

Medicare

Medicare ID: ________________________

Medicare ID #'s are 11 digit alpha-numeric

If Medicare, please complete the following questions below:

Criteria for PRP Uninsured/ State Funded Coverage Questions	Yes	No
Recently Incarcerated?		
Hospitalized for mental health within the last 6 months?		
Placed in a state hospital?		
A RRP (Residential Rehabilitation Service) Bed within the last 6 months?		

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC): _____________________________________

Type of Care (PLEASE CHECK ALL THAT APPLY, if qualified):

- __________Psychiatry
- __________Medication Management
- __________Therapy
- __________Residential
- __________PRP Services (If qualifying diagnosis)
- __________Substance Abuse Recovery Treatment
- __________ACT (Mobile Treatment)

Highest level of Education: ______________

Any arrest in the past 30 days? Y____ N_____
Currently Employed? Y____N____
Veteran? Y____ N____
In Iraq or Afghanistan? Y____N____
Is the client eligible for MTA pass? Y____N___

Any restrictions from referring agency (i.e., mobile therapy, on blackout, no telemedicine, etc.)? Y____N____

If yes, please explain:____

Is the client on parole or probation? Y____N____

If so, provide parole/probation officer's name and best contact number?

____

Office Use Only**:**

Intake date & time_______________________Therapist assigned______________________Completed by: ___________