Referral/ Triage Form

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Client's Name_____ Date of Referral _____

DOB _____ Age_____ Gender _____ SSN _____

Medicaid: □ Yes □ No

CMO (if applicable): □ Amerigroup □ WellCare □ Aetna □ Other _____

Member ID Number: _____

Parent/ Guardian Name: _____ **Relationship**: _____

Home Phone #: _____ **Cell Phone** #:_____

Other Contact Phone #: _____

Address: _____

_____

Referring Source: _____

Referring Contact Person: _____ Phone #: _____

Has Psychological been completed? □ Yes □ No (If yes, please attach to referral)

If yes, then who completed? _____ When? _____

Most recent DSM V diagnosis, if known: Axis I _____ Axis II _____

Please give a brief explanation of presenting problems:

_____

_____

Are they currently receiving service? □ Yes □ No

Suicidal: _____ Homicidal: _____

Substance Abuse: _____

Current Medical Problems/ Medications: _____

_____

_____

Current Involvement with Other Agencies (i.e. DFCS, Juvenile Court): _____

_____

OFFICE USE

□ Active □ Inactive

Accepted: □ Yes □ No

□ Urgent (w/in 2hrs) □ Emergent (w/in 48hrs) □ Routine (w/in 5 days)

Scheduled Assessment for: _____(Date/Time)

□ Kept Appointment □ No Showed □ Cancelled/Rescheduled

Notes: