Mental Health Referral Form

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Client Name: _____

Date:_____

Date of Birth: _____ Gender:_____ Social Security Number:

Parent/Guardian Name:_____ Relationship:_____

Address:

_____Phone:_____

Insurance Provider: _____

Insurance ID #: _____

Gender: _____Race (s): _____

Veteran: Yes/No Referring Source/ Agency:

_____

History/Referral Diagnoses:

_____

Client's Living Situation:

_____

_____

Client's Strengths: _____

_____

_____

What are your initial goals for treatment? _____

_____

_____

Resources that would benefit client:

_____

_____

_____

_____

Recent hospitalization __Yes No__ History of Suicidal Ideation__Yes No__

History of Psychosis __Yes No__

History of Homicidal Ideation__Yes No__ History of Substance Use __Yes No__

Reason for Referral (Please include your assessment of client's needs, recent hospitalization, recent crisis, legal issues, psychosocial stressors, barriers to treatment and other concerns. Please use a blank sheet if necessary):_____

_____

_____