**Department for Community Based Services**

**Behavioral Health Referral Form**

**The information requested below is required for the initial intake appointment. Additional information may be requested.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client information**  ***If a child is in out-of-home care, please provide the address of current placement*** | | | | | | | |
| Name: | | | | | | | |
| Gender: | DOB: | | SSN: | | | | |
| Current address: | | | Phone: | | | | |
| City: | County: | | State: | | | | Zip: |
| Primary language: | | | | | | | |
| DCBS worker name: | | County: | | | | Phone number: | |
| Client’s insurance:  Medicaid  Medicare  Private insurance  None: (Sliding scale fee)  Please indicate which MCO or private insurance company client is covered by: | | | | | | | |
| ***Please answer the following questions if client is a minor or in DCBS custody:*** | | | | | | | |
| School name: | | | | | | | |
| Child original ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OOHC start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Placement date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Caregiver of origin information** | | | | | | | |
| Name: | | | | Name: | | | |
| Address: | | | | Address: | | | |
| Phone number: | | | | Phone number: | | | |
| Relationship: | | | | Relationship: | | | |
| **Referral information** | | | | | | | |
| **Reason for referral/presenting problem for treatment *(Include symptoms of any noted developmental delays)*:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Substance abuse Peer problems Unable to focus Depression Traumatic life event Anxiety Anger management Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List of current medications: | | | | | | | |
| **Type of maltreatment:** | | | | | | | |
| Physical abuse Sexual abuse Emotional injury Neglect Exploitation Dependency  Other | | | | | | | |
| Previous mental health/substance use treatment:  Yes  No  If yes, previous provider agency and staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Please ensure the following items are submitted with this referral form for scheduling: | | | | | | | |
| * Screener report * Court orders regarding guardianship, custody, or care of the client * Release of information and consent to treat | | | | | | | |
| *CMHC cannot provide treatment without current guardian’s signature on intake forms due to HIPAA and other state and federal regulatory requirements. If the individual being referred is a minor or an adult who has a court-appointed guardian, CMHC must have information indicating the person with authority over the referred individual who can sign for treatment. Any custody orders, divorce decree, or guardianship orders with individual responsible for medical treatment and that person’s current contact information should be included with the submission of this referral form. Additionally, if in foster care, DCBS must sign for consent for treatment.* | | | | | | | |
| **DCBS worker signature:** | | | | | **Date:** | | |