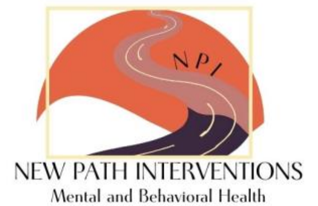

SERVICE REFERRAL FORM

Date of Referral: ___________________ Name of Individual: ____

Name of Parent/Legal Guardian: ____

Individual's Date of Birth: ____________________________ Medicaid ID: ________________________________

Address: ____

Phone Number: ______________________________Referring Individual/Agency: __________________________

Current Medication____

Which Service are you requesting: ☐ Mental Health Skill Building ☐ Intensive In-Home

☐ Other: ____

<u>Please check all of the following behaviors that apply to the referred individual:</u>

- ☐ Depression
- ☐ Frequent Interpersonal conflicts
- ☐ Hallucinations
- ☐ Harm or injury to self
- ☐ Suicide attempt(s)
- ☐ Excessive worry/Anxiety
- ☐ Panic attack
- ☐ Bad temper/irritability
- ☐ Defiance of rules
- ☐ Argumentative
- ☐ Stealing
- ☐ Legal Involvement
- ☐ Problem with Authority
- ☐ Verbal Aggression
- ☐ Physical Aggression
- ☐ Poor Attention or Concentration
- ☐ Impulsive
- ☐ Hyperactive
- ☐ Impaired academic/work skills
- ☐ Truancy/Frequent suspensions
- ☐ Alcohol/substance abuse
- ☐ Homelessness
- ☐ Isolation from social support
- ☐ Medication Management
- ☐ Other: ____