STILL FAMILY, LLC

Referral form

 Referral Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Contact Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral e-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone #: \_\_\_\_\_\_\_\_\_\_

Marital Status: □ Single □ Married □ Divorced □ Separated

Address:

|  |
| --- |
|   |

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: □ Residential □ Consultative Services □ Innovations ID/DD\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Presenting Problems or Reason for Services:** |
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|   |
|   |
|  |
| **Client’s/Families Strengths:** |
|   |

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| **Person Legal Guardian:** |
|  |
|  |
|  **Diagnosis (must have DSM 5 Axis I, II, III, IV, ):** |
|   |
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|  |
| **Suicide or elopement potential:** |
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|   |

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Developmental Condition or Impairment (obtained from diagnosis):

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Substance Abuse or Use (including previous treatment, onset, type of drug):

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Legal Status or Circumstances:

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Medical Conditions, Including Medical History:

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Current Medications:

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Agencies Working (worked) With Client:

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| --- | --- | --- |
| Agency | Name of Contact Person | Phone Number |
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Educational History (include any problems/special needs etc.):

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*Signature of Referring Agent Date*

*Accepted for services Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Fax Referral form to (704) 405-4547*