

**Date of Referral:** \_\_\_\_\_

- Outpatient Therapy (OP)   
  In-Home Therapy (IHTS)   
  Preschool Day Treatment (PASS)  
 Skills Services (CTSS)   
  Intensive Home Therapy (CIBS/SFT/CRS)   
  Early Childhood Program (ECH)   
  Parent Education Program (SST/PE)  
 School Based Grant   
 School Name: \_\_\_\_\_ District: \_\_\_\_\_ Grade: \_\_\_\_\_

**Client Information**

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Client Gender:     Male     Female     Other: \_\_\_\_\_

Employment Status:     Full-Time     Part-Time     Not Employed     Retired     Disabled     Active Military     Other: \_\_\_\_\_

Student Status:     Full-Time     Part-Time     Not a Student

Primary Caretaker:     Mother     Father     Both     Other: \_\_\_\_\_

Legal Guardian:     Mother     Father     Both     Other: \_\_\_\_\_

**Parent Information** (if client is a child)

Parent 1 Name: \_\_\_\_\_ Parent 2 Name: \_\_\_\_\_

Address:     Same as above     Different from above    Address:     Same as above     Different from above

\_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referral Information**

Referral Source: \_\_\_\_\_ Agency/Division: \_\_\_\_\_

Referral Email: \_\_\_\_\_ Referral Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Current Social Services/Probation/Psychological Services Involvement?     Yes     No

Date of last DA: \_\_\_\_\_ Within the last 6 months?     Yes     No    Has client received any previous mental health services?     Yes     No

Clinic/Therapist: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

**Patient Registration Form/Insurance Verification**

Client is uninsured:

**Primary Insurance Coverage**

Insurance Name: \_\_\_\_\_

Insurance Group/Account #: \_\_\_\_\_

Policy/Individual/Member#: \_\_\_\_\_

1-800 #: \_\_\_\_\_

Employer: \_\_\_\_\_

Co-Pay Amount: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

Policy Holder Gender:  Male  Female  Other: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder City/State/Zip: \_\_\_\_\_

**Secondary Insurance or EAP Coverage**

Insurance Name: \_\_\_\_\_

Insurance Group/Account #: \_\_\_\_\_

Policy/Individual/Member#: \_\_\_\_\_

1-800 #: \_\_\_\_\_

Employer: \_\_\_\_\_

Co-Pay Amount: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

Policy Holder Gender:  Male  Female  Other: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder City/State/Zip: \_\_\_\_\_