Nexus-FACTS FAMILY HEALING

Referral Intake

Date of Referral: _____

☐Outpatient Therapy (OP) ☐In-Home Therapy (IHTS) ☐Preschool Day Treatment (PASS)

☐Skills Services (CTSS) ☐Intensive Home Therapy (CIBS/SFT/ITFC/CRS) ☐Early Childhood Program (ECH) ☐ Psychological Testing

Client Information

Client Name:_____ Age:_____ DOB:_____

Client Address: _____

City:_____State:_____Zip:_____

Home Phone: _____ Cell Phone:_____

Email Address: _____

Client Gender: ☐Male ☐Female ☐Other:_____

How do you identify racially? Choose all that are appropriate

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Other: (please specify) _____
- ☐ Decline to answer

Do you identify as either Hispanic or Non-Hispanic?

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Decline to answer

Please share your ethnicity. Ethnicity refers to shared culture, such as language, ancestry, practices, and beliefs (e.g., Greek, Mexican, Somali, Vietnamese, etc.)

_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Active Military ☐ Other: _____

Do you require financial assistance to pay for services? ☐ Yes ☐ No

If yes, please list your gross yearly income _____

How many people are in your household (including yourself)? _____

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

School Name: _____ District: _____ Grade: _____

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: _____

Nexus-FACTS FAMILY HEALING

Referral Intake

Referral Information

Referral Source: _____

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 #: _____

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 #: _____

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: _____

Who suggested you reach out to Nexus-FACTS about services? (If you are a provider referring a client, please list your name and agency)

Name: _____

Agency Name: _____