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| **Date of Referral** |  | **Person**  **Completing Form** |  | **Person**  **Providing Info** |  |

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| **REFERRAL**  **REGION** | Pulaski/Somerset | McCreary/Whitley City | Wayne/Monticello | Jefferson/Louisville Metro |
| Telehealth/Statewide | Other (please list): | | |

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| **DEMOGRAPHIC INFORMATION (OF CLIENT/PERSON SEEKING SERVICES)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Full Legal Name**  **\*Note: As listed on ID/insurance** | | | | | | | |  | | | | | | | | | | | | | **Other Names Client Goes By (if different)** | | | | | | | | |  | | | | | |
| **DOB** |  | | | | | | | | | | | | | **Age** |  | | | | | | **SSN** | | | | | | | | |  | | | | | |
| **Sex (Assigned At Birth)** | | | | | Male  Female  Other: | | | | | | | | | | | | **Gender Identity** | | | | | | Male  Female  Other: | | | | | | | | | | | | |
| **Race** |  | | | | | | **Religion** | | | | | |  | | | | | | | **Pronouns** | | | He/him She/her They/them  Other (please list): | | | | | | | | | | | | |
| **CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mailing Address** | |  | | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | | | | | |  | | |
| **Physical Address (if different from mailing)** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **E-mail Address** | | |  | | | | | | | **Parent/Guardian Name(s)** | | | | | | | | | | | |  | | | | | | | **Relationship** | | | | | |  |
| **Guardian Phone** | | |  | | | | | | | **Emergency Contact Name** | | | | | | | | |  | | | | | | | | **Emergency Contact Phone** | | | | | | | |  |
| **Primary Care Physician (PCP)** | | |  | | | | | | | | | | | **PCP**  **Phone #** | | | | |  | | | | | **PCP Address** | | | | |  | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Medicaid ID (MAID), if applicable*** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***PRIMARY INSURANCE*** | | | | | | | | | | | | | | | |  | | ***SECONDARY INSURANCE (if applicable)*** | | | | | | | | | | | | | | | | | |
| ***Insurance Provider/ MCO*** | | | | | |  | | | | | | | | | |  | | ***Insurance Provider/ MCO*** | | | | | | | | | | | | |  | | | | |
| ***Name of Insured Person*** | | | | | |  | | | | | | | | | |  | | ***Name of Insured Person*** | | | | | | | | | | | | |  | | | | |
| ***Policy #/MCO ID*** | | | | | |  | | | | | | | | | |  | | ***Policy #/MCO ID*** | | | | | | | | | | | | |  | | | | |
| ***Group #*** | | | | | |  | | | | | | | | | |  | | ***Group #*** | | | | | | | | | | | | |  | | | | |
| **RESPONSIBLE PARTY INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | |  | | | | | | | | | | | | | **Relationship** | | | | | | | | | | | |  | | | |
| **DOB** | | | | | | |  | | | | | | | | | | | | | **Gender** | | | | | | | | | | | |  | | | |
| **Address** | | | | | | |  | | | | | | | | | | | | | **Phone #** | | | | | | | | | | | |  | | | |
| **REFERRAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Source** | | | |  | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | | | | | |  | |
| **Reason for Referral/Presenting Problem** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date/Time of Intake** | | | |  | | | | | | | | | | | | | | | **Location of Intake** | | | | | | | | |  | | | | | | | |
| **Assigned Clinician** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **- - - - - - - - CLINICIAN USE ONLY - - - - - - - -** | | | | | | | | | | | |
| **Screening Completed** | CAPS Patient Stress Questionnaire  Other (please list): | | | **Referred for Staffing** | | | No Yes  If yes, list date: | | | | |
| **Screening Results Indicate** | |  | | | | **Provisional Diagnosis** | | | |  | |
| **Case terminated & referred for other services** | | | No Yes  If yes, list agency: | | | | | **Case terminated & no further service is requested** | | | No  Yes |
| **Clinician Signature/Title/Date** |  | | | | **Supervisor Signature/Title/Date** | | | |  | | |