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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 [ ] YesIf 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** |  |