Please Call (281)-846-6333

# Community Referral Form

Date: ____________________________

## Client Information

| Last Name: | First Name: | Date of Birth: | Gender: Male Female |
|---|---|---|---|
| Current Address: | | Phone/Mobile Number: | |
| Responsible Party: | Relationship/Role: | | |

## Referral Source

| Referral Contact: | Phone Number: | Email: |
|---|---|---|

## Financial and Insurance Information

Managed Care Organization (MCO):

| Medicaid | | Community Health Choice | Molina |
|---|---|---|---|
| Superior | Texas Children's Health Plan | United Healthcare | Unknown |

| Policy Number: | Group Number: |
|---|---|

## Symptoms and Behaviors

| | | |
|---|---|---|
| Anxiety, irritability | Argumentative or uncooperative | Poor School Functioning |
| Depression | Criminal / Juvenile behavior | Family Concerns / Conflict |
| Substance abuse | Emotional outbursts | Impulsive / Hyperactive |
| Aggressive / Disruptive Behavior | Suicidal Ideation | Decline in functioning |
| Educational Concerns | Low self-esteem | Inappropriate sexual behavior |
| Sets Fires /Animal abuse | Runaway behaviors | Self-abuse or mutilation |
| Social isolation | Danger to self or others | Poor decision making |
| Poor appetite/weight problems | Non-compliant with medical/nurse care | Other (Specify): ______________________________ |

None Known:

## Additional Information

How long has the client had services with you?

Prior Mental Health / Rehabilitation Agency?

Prior Hospitalization?

Safety concerns. Yes No

Is there any potential for violence or harm to anyone in the home?

Concerns for physical health or basic needs?