Program Referral Form

Fax referrals to (216) 916-4803

Date: _____

Referral Source:_____

Contact Person: _____ Phone: _____

Email: _____

Client Name: _____

Last First Middle

DOB: _____ Social Security Number: _____

Marital Status: _____ Ethnicity/Race: _____

Insurance Provider: _____ Insurance Number:_____

Program Referral:

___ LIFTED Men ___ Teen Prevention Program ___ Emotional Regulation ___ Mental Health Services

Reason for referral: _____

_____

List any allergies: _____

List any mental health/medical diagnosis: _____

_____

List all medications: _____

_____

Place a check indicating a history of or current behaviors:

____ self-injurious behaviors ____ suicidal thoughts/attempts ____ violence towards others

____ sexual abuse (perpetrator or victim) ____ property destruction ____ victim of violence

____ acting out behaviors (toileting issues, playing with fire, etc.) ____ substance use/abuse/dependency

Other: _____

Emergency Contact Name: _____

Address: _____

Phone: _____ Relationship: _____

****

Date Received: _____

Date and staff assigned for intake: _____

Accepted into services: _____ yes _____ no If no, explain: _____

_____

_____