



## REFERRAL FORM

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### Referral Source:

Name/Title: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_ City/Town: \_\_\_\_\_

E-mail: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Funding Source:  FAPT/CPMT  Medicaid

Medicaid #: \_\_\_\_\_ Medicaid Provider: \_\_\_\_\_

### Student Data:

Full Name of Client: \_\_\_\_\_ SSN#: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ School Attending: \_\_\_\_\_

Has the client ever been hospitalized for psychiatric care?  Yes  No

If yes, was the hospitalization within the past 30 days?  Yes  No

### **(Child services only)**

Parents/Guardians Name(s): \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Street Address (or "same as student"): \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Child is at risk of removal from:  Home  School  Community

Explain why child is at risk of removal: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

### **(TDT Services only)**

I (parent/guardian) \_\_\_\_\_ of (child) \_\_\_\_\_  
hereby authorize (school) \_\_\_\_\_ to exchange all information as necessary for the  
purpose of assessment, evaluation, and treatment with Anderson Counseling Services.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(For in-school referrals verbal permission is allowed)  Verbal permission granted on: \_\_\_\_\_ Initial: \_\_\_\_\_

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**List of current service providers involved with the child: List Name, Title and Phone number below:  
(ie; Psychiatrist, Therapist, Social worker, Probation officer, Foster parent)**

NAME	TITLE	TELEPHONE #

Please call our main office with any questions pertaining to this form or the referral process. 434-239-2004 ext. 105

**-----For Office Use Only-----**

Referral received date: \_\_\_\_\_

Referral appropriate?  Yes  No

If no, state reason:

\_\_\_\_\_

Referral given to:  Therapeutic Day Treatment  Intensive In Home  Mental Health Skill Building

Admissions Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_