Attachment C
Rev. 1/2020

Department for Community Based Services
Behavioral Health Referral Form

The information requested below is required for the initial intake appointment. Additional information may be requested.

Client information

If a child is in out of home care, please provide the address of current placement

Name:			
Gender:	DOB:	SSN:	
Child's address:		Phone:	
City:	County:	State:	Zip:
Primary language:			
School name:			

Reason for referral/presenting problem for treatment *(Please indicate if Michelle P assessment is requested)*: _____

_____

_____

_____

☐Substance abuse ☐Peer problems ☐Unable to focus ☐Depression ☐Traumatic life event ☐Anxiety ☐Anger management

☐Other_____

List of child's current medications:

Type of maltreatment:

☐Physical abuse ☐Sexual abuse ☐Emotional injury ☐Neglect ☐Exploitation ☐Dependency

Previous mental health/substance abuse treatment: ☐ Yes ☐ No

If yes, previous provider: _____

Provider phone number: _____

Client's insurance: ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ None: (Sliding Scale Fee)

Please indicate which MCO or private insurance company client is covered by:

Caregiver of origin information

Name:	Name:
Address:	Address:
Phone number:	Phone number:
Relationship:	Relationship:

DCBS information

Please complete this section if child is currently in the custody of DCBS ☐ N/A

Child original ID: _____	DCBS worker name: _____
OOHC start date: _____	County: _____
Placement date: _____	Phone number: _____
Placement name: _____	

Please ensure the following items are submitted with this referral form for scheduling

- Screener report
- Court orders regarding guardianship, custody, or care of the client
- Release of information and consent to treat

CMHC cannot provide treatment without current guardian's signature on intake forms due to HIPAA and other state and federal regulatory requirements. If the individual being referred is a minor or an adult who has a court-appointed guardian, CMHC must have information indicating the person with authority over the referred individual who can sign for treatment. Any custody orders, divorce decree or guardianship orders with individual responsible for medical treatment and that person's current contact information should be included with the submission of this referral form. Additionally, if in foster care, DCBS must sign for consent for treatment.

DCBS worker signature:	**Date:**