

Referral Source Printed Name & Institution: _____
 Referral Source Signature: _____
 Referral Date: ___/___/___

Client Demographic Information

Client's Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Daytime Number: () _____ Home/Other: () _____
 Date of Birth: ___/___/___ Social Security Number: ___-___-___
 Race: ___ Ethnicity: _____ Marital Status: _____ Gender: _____ Current Level of Education: _____
 Employment Status: _____ # of Arrests in past 30 days: _____
 Veteran: YES/NO If yes, which war(s)? _____, _____, _____

Insurance Details

Insurance Type: _____ Maryland Medicaid #: _____
 Primary Insurance Holder's Name and D.O.B.: _____
 Private Insurance Group #: _____ Private Insurance Member #: _____

Custodial/Guardianship Information

Parent/Guardian Name: _____

- Minor: Is the custodian the biological parent of the client? YES NO N/A
- Minor: Does the custodian have legal custody of the minor? YES NO N/A
- Adult: Does the client have a legal guardian appointed? YES NO N/A

If parent does not have custody, please provide custodial information:

Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

Referral Information

Reason for Referral (*Client Needs and Presenting Issue*)

Preferred day/time of appointment: _____
 Other Preferences: _____

Risk Assessment & Prior Treatment Questionnaire (*Please respond Yes/No/N/A*)

Suicide Risk: ___ Danger to Self or Others: ___ Urgent/Critical Medical Condition: ___ Immediate Threat(s): ___
 Past Psychiatric Admission(s): ___ Previous Outpatient Treatment: ___
 Previous/Current Outpatient Provider: _____ Phone: _____
 AXIS I _____ AXIS II _____ AXIS III _____