Pathways
Transition Programs, Inc.

120 East Trinity Place • Decatur, GA 30030 Phone (404) 378-2300 • Fax (404) 378-2394

REFERRAL FORM

If other than self-referral or caregiver referral

REFERRAL SOURCE		
Name:	Agency	Date:
Phone #:	Fax #:	E-mail Address:

CLIENT INFORMATION *(Confirm correct name spelling and DOB with client and/or guardian.)*		Male Female
First Name:	Last Name:	DOB:
Social Security #:	Insurance Name and Number:	
Street Address:		Apartment/Unit #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Name of School:		

If the client is a child or adolescent, please complete the following

CAREGIVER #1 INFORMATION	Relationship to Child:	
First Name:	Last Name:	DOB:
Street Address:		Apartment/Unit #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
CAREGIVER #2 INFORMATION	Relationship to Child:	
First Name:	Last Name:	DOB:
Street Address:		Apartment/Unit #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Do the caregivers have full custodial rights to make medical and educational decisions for this child?	Yes	No
Is there another parent or caregiver with joint custody we should inform about treatment?	Yes	No
Does the client have thoughts of self-harm or of harming others?	Yes	No
Does the client have an urgent or critical medical condition?	Yes	No
Does the client have a safety threat?	Yes	No

REASON FOR REFERRAL? OTHER COMMENTS?			
Requested Services:	Counseling	Medication Management	Diagnostic/Assessment

Please note: medication management services are only available for clients receiving counseling services. We are unable to accept referrals for medication management only.