



120 East Trinity Place • Decatur, GA 30030

Phone (404) 378-2300 • Fax (404) 378-2394

REFERRAL FORM

DATE:

If other than self-referral or caregiver referral

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

CLIENT INFORMATION		<input type="checkbox"/> Male <input type="checkbox"/> 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:

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:	

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

Reason for referral? Other Comments?			
Requested Services:	<input type="checkbox"/> Counseling	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Diagnostic/Assessment