Sigma Health Services, LLC

Screening/Referral Form

Date: _____ **MR#:** _____

☐ **Clinical Assessment** ☐ **SAIOP** ☐ **ACE** ☐ **DWI** ☐ **Outpatient Therapy**

Client Name: First _____ **Last**_____ **SS#:** _____

DOB: _____ **Sex:** _____ **Race:** _____**Marital Status:** _____

Circle Insurance: Medicaid HealthChoice BCBS Self-Pay Policy #: _____

Address:_____

City: _____**State:** _____ **Zip Code:** _____ **County:**_____

Phone: (home) _____ **(work)**_____**(cell)**_____

Employer/School:_____**Phone #:**_____

Guardian/Emergency Name:_____**Contact #:**_____

Relation to Consumer: ☐ **Mother** ☐ **Father** ☐ **Relative** ☐ **Other** _____

Reason for Contact:

_____

_____

_____

SA/Mental Health Diagnosis (if known):

_____

_____

Prescribed Medications and Compliant:

_____

_____

Medical Issues:

_____

Referral Information:

Referral Source: _____ **Contact Name:** _____ **No:** _____

Community Engager: _____ **Dept:** _____ **No:** _____

Had Previous MH Services: _____

Currently in Service: _____ **Agency:** _____

Providers Currently Involved:

Is this a Child Protective Services Case? _____ **Is the Consumer under TDM/Court Order?** _____

Does the Consumer have legal issues/On Probation? _____ **If yes, explain.** _____

_____

Is the Consumer homeless/at risk of being homeless? _____ **Is Consumer in a shelter?** _____

Agency: **Contact Name:** **Telephone #:**

_____

_____

_____

Additional Comments or Concerns:

_____

_____

_____

Internal Use Only:

Date Received: _____**Date of Screening:** _____ **Screening Method: Telephone or Face to Face**

Clinical/Diagnostic Assessment Scheduled: _____

Signature/Credentials and Date of Staff Completing Screening:

_____ **Date:** _____

***If client does not meet services criteria of Sigma Health Services, they're referred to Alliance Behavioral Health Services. Their contact number is (919) 651-8401.**