Sigma Health Services, LLC

Consumer Referral Form

REFERRAL INFORMATION

Date/Time of Referral: ______

Referred By: ______

Admit Date: ______

Agency: ______

Phone Number: ______

Service Requested: ______

Please include with referral:

- ☐ Medical Service Order (psych/other assess.)
- ☐ Service Authorization
- ☐ Intake Assessment (Target pop. form)
- ☐ Service Plan
- ☐ Referral Form

CONSUMER INFORMATION

Consumer Name - Last Name: ______ First Name: ______ Middle/Maiden: ______

Date of Birth: ______ Race: ______

Marital Status: ______ Gender: ◯ Male ◯ Female

Consumer Phone Number: (home) ______ (work): ______

Consumer Medicaid Number: ______ Social Security Number: ______

Consumer Address: ______ Name of Parent(s)/Guardian: ______

Relationship to Consumer: ______

Number in Household: ______ Highest Grade Completed: ______

Household Income: ______

MEDICAL AND EMERGENCY INFORMATION

Person to Contact in Case of Emergency: ______ Relationship to Consumer: ______

Emergency Contact Address: ______

Emergency Contact Phone Number: ______

Allergies (List): ______ ☐ None Known

Physician: ______ Phone Number: ______

Current Medications and Dosages: ______

Diagnosis (If Known):

TYPE	DSM CODE	DIAGNOSIS	DATE	THERAPIST
AXIS I				
AXIS II				
AXIS III				
AXIS IV				
AXIS V				

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REFERRAL BEHAVIOR (Please Check All That Apply)

- ☐ Verbal and Physical Aggression
- ☐ Property Destruction
- ☐ Robbery
- ☐ Truancy
- ☐ School Drop-Out
- ☐ Problems Within Family System
- ☐ Noncompliance with Family or Community Rules
- ☐ Currently on Probation
- ☐ At-Risk for Out-of-Home Placement
- ☐ Other
- ☐ Violent Behavior (Causing Injury)
- ☐ Property Theft
- ☐ Drug Use or Abuse/Dependency
- ☐ Drug Possession or Distribution
- ☐ Academic Failure
- ☐ Disruptive Behavior in School
- ☐ Affiliation with a Formal Gang
- ☐ Multiple Court/Police Involvements
- ☐ Youth Returning Home from Placement

Explanation:

OTHER AGENCIES/SERVICE PROVIDERS INVOLVED WITH CONSUMER?

NAME OF AGENCY	CONTACT NAME	CONTACT PHONE NUMBER

NAME OF SCHOOL	CONTACT NAME	CONTACT PHONE NUMBER

Discharge Date: