# CORE & IFI PROGRAMS

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| Referral Form |
| **Name:**  | **Referral Date:** |
| Address:  | **Client’s SSN:**  |
|  | **Referral Name:**Number:Fax:**Email:** |
| County:  |
| **Phone:** Cell: |
| Ethnicity: Country of Birth: | **Gender:** \_\_M \_\_F | **Date of Birth:**  |
| Additional Contact(s) |
| Parent/Guardian/Representative: Phone:Address: Email: |
| Insurance Information |
| **Insurance Name:**  | **Primary Insurance Holder:**  |
| **Policy #:** | **Primary SSN:** |
| **Group #:** | **Primary Address:** |
| **Ins. Co. Phone #:**  | **Address:**  |
| **Name of Ins. Plan:** |
| Medical Information |
| Allergies: Allergies: (Y) or (N) *If yes specify:* | Seizures: (Y) or (N) *If yes specify:* |
| **PCP Name:** | **PCP Address:** |
| **PCP Phone Number:** |  |
| **Present Prescribed Meds/Dosage/Frequency:** |
|  |  |
|  |  |
| **Behavioral Health History:** What are the last three places that you ever received Behavioral Health Services and/or Substance Abuse Services? |
| 1. | 2. |
| 3. |
| **Diagnosis:** |
| 1. Primary 2. Secondary 3. Other |
| **Judge Name (If Applicable):** |
| Name Number:  |
| **Comments** (Current Charges, DAI Score, Reason for Referral, Etc**):**  |
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**Please fax this form to (678) 892-8575 or call (678) 344-7836 if there are any questions.**

**OFFICE USE ONLY**

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| Date Received |  | Date Assigned |  |