Mental Health Services
Registration-Referral Form

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Select One: ☐ Diagnostic Assessment ☐ Medication Management ☐ Individual Therapy ☐ Family Therapy

Referral Source (Name & Relationship):				Phone #:
Client Information				
Client Name:			DOB:	SS#:
Address:		City:		County:
State:	Zip Code:	Home Phone: ( )	Work Phone: ( )	
Age:	Sex:	School:		Grade:
Ethnicity:		Tribal Affiliation:		Religion:
Check One:	Parent(s): ☐	Guardian(s): ☐	Name(s):	
Address:			Home Phone: ( )	
City:	State:	Zip Code:	Work Phone: ( )	
County:		Sex:	Relationship:	

Other Children Living in the Home	Age	Other Children Living in the Home	Age
1.		3.	
2.		4.	

Present Interventions/Services Being Provided to the Family	
Case Manager/Social Worker:	Children's Mental Health Worker:
Outpatient Mental Health Agency:	Outpatient Mental Health Provider:
C.D. Treatment Agency:	C.D. Treatment Provider:
Probation Agency:	Probation Officer:
Psychiatric Service Agency:	Psychiatric Service Provider:
Current Foster Home:	Other Service Providers:

Current Pharmacy

Current Family Situation

Identified needs to be addressed and specific outcomes expected

Below is intended for office use only

Referral Received Date:	M.A.☐ I.M. Care ☐ Other ☐ :		Ins. #:
Insurance Verification Date:	DA Requested: ☐	Date DA Requested:	D.A./Psych Eval Date:
Date Outside DA to MHP for Approval:		Assigned MH Practitioner:	
Developmental and mental health needs can be met by CTSS Services: ☐ yes ☐ no			Ok to Open: ☐