



REFERRAL FORM

Please complete and fax to 404-324-4191 or email to counseling.center@chriskids.org

Referral Source

Contact Name: \_\_\_\_\_

Organization (DFCS, school name, doctor's office): \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email address: \_\_\_\_\_

Relationship to Consumer: \_\_\_\_\_

Consumer's Name: \_\_\_\_\_ Gender/Ethnicity: \_\_\_\_\_

DOB: \_\_\_\_\_ Parent or guardian's name \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

History of Problems: \_\_\_\_\_

Current Medical Problems/Medications: \_\_\_\_\_

Current Involvement with Other Agencies/Doctors/Clinicians: \_\_\_\_\_

History of prior MH/SA treatment and response: \_\_\_\_\_

Services Requesting: (Check all that apply):

- IFI    Individual    Crisis    Diagnostic Assessment    CSI    Nursing Assessment
- Family Counseling    Group Counseling    Medication Administration    Physician Assessment

If you are a referral source, please indicate by signing below that you have discussed the referral with the appropriate guardian. Please indicate that you  have or  do not have permission to receive notification regarding follow-up to this referral.

Signature \_\_\_\_\_ Date \_\_\_\_\_

CHRIS Kids Counseling Center Use Only	
Accepted: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred to: _____
Scheduled for: _____ <input type="checkbox"/> Urgent (W/in 2hrs) <input type="checkbox"/> Emergent (W/in 48 hrs) <input type="checkbox"/> Routine (W/in 5 days)	