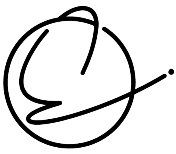

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REFERRAL FORM

Referring Facility:____________________ Referring Person: ____________________ Date: ____________

Reason for Referral: ____

____

Client Name: ______________________________________ Date of Birth: _______________________

Address: ________________________________ City:________________ State: _____ Zip: _________

Phone Number: ___________________ Email: ____

Are there transportation barriers: ☐ Yes ☐ No Explain: ____

Previous: ☐ Diagnostic Assessment ☐ Rule 25 Assessment ☐ Comprehensive Assessment

Where: __________________________________ When: _____________________ (We will need a copy)

Where: __________________________________ When: _____________________ (We will need a copy)

Where: __________________________________ When: _____________________ (We will need a copy)

Current Care Team

Court Ordered	☐ Yes ☐ No	Name: ______________________ County: _____________________
Probation Officer	☐ Yes ☐ No	Name: ______________________ County: _____________________
Case Manager	☐ Yes ☐ No	Name: ______________________ County: _____________________
CHIPS Worker	☐ Yes ☐ No	Name: ______________________ County: _____________________
Therapist	☐ Yes ☐ No	Name: ______________________ Facility: _____________________
Primary Physician	☐ Yes ☐ No	Name: ______________________ Facility: _____________________

Fax or email this referral form with any supporting documentation.