Outpatient Screening/Referral Form

Updated: 3/20/2020

CLIENT INFORMATION			
Client Name:	DOB:	Age:	Gender: ☐ M ☐ F
Home Address:			
Phone (home):	Phone (other):	Primary Language:	
Parent/Guardian – **for Minors**	Relationship to Minor		
Insurance #	Record #	Expiration Date	
Reason for Referral & Frequency of Symptoms			
Person Making Referral	Phone #	Email	

REFERRAL RECOMMENDATIONS

☐ Clinical Assessment ☐ Outpatient Therapy ☐ Peer Support ☐ Individual Support

ACUITY OF NEED	Appointment Date & Time:
☐ Routine – contact 14 calendar days ☐ Urgent – contact 2 calendar days ☐ Emergent (immediate)	

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