Positive Steps LLC
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Please fax to 410-779-9147

Referral Form

Client Name: _____ **Date of referral:** _____
SSN: _____ **Medical Assistance #:** _____

Gender: _____ **Race:** _____ **DOB:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Legal Guardian (if applicable): _____
Relationship: _____

Reason for Referral: _____
_____
_____
_____

Pervious Mental Health Providers: _____
_____

Requested Services: (Please check all that apply)

- **Diagnostic Assessment** ☐
- **Individual Therapy** ☐
- **Family Therapy** ☐
- **Group Therapy** ☐
- **Anger Management** ☐
- **DUI Education Classes** ☐
- **Substance Abuse Counseling** ☐
- **Psychiatric Services** ☐
- **Other (please explain)** ☐

_____
_____
_____
_____

Does this client have a history of suicidal ideations or attempts? ☐ **YES** ☐ **NO**
If yes, please provide details:
_____
_____

Referral Source

Name: _____ **Email:** _____
Phone: _____ **Fax:** _____
Agency: _____