POSITIVE steps
one step at a time

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Referral Form

Client Name: _____ **Date of referral:** _____ **Medical Assistance #:** _____
SSN: _____ **Gender:** _____ **Race:** _____
DOB: _____ **Age:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Address: _____
City: _____
State: _____
Zip: _____

Legal Guardian (if applicable): _____
Relationship: _____

Living Situation:

Primary Diagnosis:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Diagnosis given by: _____
Date of diagnosis: _____

Is there documentation to verify this diagnosis? **Yes** ☐ **No** ☐
Is the client currently receiving therapy? **Yes** ☐ **No** ☐

Medications:

Reason for Referral (check all that apply):

☐ Behavior/Conduct Challenges ☐ Emotional ☐ Educational Problems ☐ Employment Instability
☐ Financial Instability ☐ Legal/Incarceration ☐ Medication Mismanagement ☐ Physical/Emotional Abuse
☐ Relational Conflicts ☐ Sexual Abuse ☐ Social/Interpersonal Challenges ☐ Substance Abuse
☐ Suicidal/Homicidal

PRP Services Requested (check all that apply):

☐ Adaptive Resources ☐ Crisis Intervention ☐ Dangerous Behaviors
☐ Education/Vocational Training ☐ Health Promotion ☐ Independent Living Skills
☐ Self-Care Skills ☐ Social Skills
☐ Psychiatric Inpatient/Detention Center Support ☐ Social Relationships & Leisure Activities
☐ Promotion of Wellness, Self-Management, & Recovery

Symptoms and Behaviors/Risk Behaviors (check all that apply):

☐Anxiety/Panic	☐Attachment Problems	☐Depressed	☐Fire Setting	☐Homicidal Ideations
☐Hopeless/Helpless	☐Hyperactive	☐Impulsive	☐Irritable	☐Isolative
☐Lying/Manipulative	☐Manic Mood	☐Obsession/Compulsion	☐Oppositional Defiant	☐Physical Aggression
☐Property Destruction	☐Running Away	☐Self-Care Deficit	☐Self-Injurious Behavior	☐Separation Problems
☐Sexually Inappropriate	☐Social/Withdrawal	☐Stealing	☐Suicidal Ideation	☐Trauma-related
☐Truancy	☐ Verbal Aggression			

Referring Therapist (must be a licensed therapist):

Name: _____ **Credentials:** _____ **Email:** _____

Phone: _____ **Fax:** _____ **Agency:** _____

Therapist Signature: _____ **Date:** _____