INSTITUTE FOR LIFE ENRICHMENT CLIENT REFERRAL FORM

DATE of Referral: ____/____/_______

Clients Name: ____ DOB: ______________ Age: ________________

Address:_____________________________________ City: ___________________ State: ______ Zip:_________

Home phone: ____________________ Cell phone: __________________________ Male____ Female ____

Social Security# _______________________ Uninsured / Insured

MA#_______________________________ Ethnicity ___________

Marital Status: Single___ Married___ Separated/Divorced ___ Remarried ___ Veteran: Yes ___ No___

LEGAL CUSTODIAN (for minors/dependents):
***NOTE: Court documentation regarding custody status must be included with referral form.**
Primary DSS or DJS Custody? __ yes ___ no ___ n/a Court ordered attached to referral (if yes) _________

Name: ____Relationship:______________________________

Work Phone#: (______)_______________________ Home#:(_______)________________________________

Address: ______________________________________City: __________________ State:______ Zip:__________

REFERRAL SOURCE:
Agency: ____________________________________ Contact Person/***Credentials***:___________________________

Phone: (______) _____________________Ext. ________ Fax :(______) _______________________

Address:__________________________________ City: ______________________ Zip:____________

MOST RECENT MENTAL HEATLH TREATMENT: Currently being treated? Yes____ No____
Agency: ____________________________________ Therapist Name/***Credentials***:____________________________
Address:____ City: _________________ Zip:_______________
Phone: (______) ______________ Ext. __________ Other: (_______)___________Fax: (_____) _________________
Therapist email address: ____

DSM IV DIAGNOSIS *NOTE: MUST INCLUDE A COMPLETE AXIS I-V*
AXIS I: ____________________________ AXIS IV__________________________
____________________________ AXIS V: ________ Highest Past year:_________
AXIS II: ____________________________ Diagnosed by: ________________________________
AXIS III: ____________________________ Date Diagnosed: ________________________________
MEDICATIONS: ____

REASON FOR REFERRAL: ____
____
____

INSTITUTE FOR LIFE ENRICHMENT CLIENT REFERRAL FORM

____

HISTORY OF PRESENTING PROBLEM (INCLUDE RECENT ER VISITS OR OTHER CRISIS INTERVENTIONS)

____
____
____
____

FAMILY FUNCTION/HISTORY:

____
____
____

Problems with Family Relations? _______Custody/Placement?_______ Living Situation? ___________

******PLEASE SUBMIT DISCHARGE SUMMARY, REPORTS OF TREATMENT PLANS, TESTS AND PRIOR EVALUATIONS******

____

HISTORY OF SUBSTANCE ABUSE (note if current usage): ____
____

HISTORY OF SUICIDAL/HOMICIDAL ATTEMPTS OR IDEATION: ______________________________
____

HISTORY OF HOSPITALIZATION AND/OR RESIDENTIAL PLACEMENT:

DATES	FACILITY	REASON FOR ADMISSION
______	________________________	________________________________
______	________________________	________________________________
______	________________________	________________________________

CONSUMER WILL NEED TO PROVIDE THE FOLLOWING INFORMATION AT INTAKE IN ORDER TO RECEIVE SERVICES:

a. Social security card
b. Birth certificate
c. Court order (if applicable)
d. Medical assistance card

Please have client acknowledge they received the information.