INSIGHTFUL THERAPEUTIC SERVICES OUTPATIENT MENTAL HEALTH CLINIC REFERRAL

DATE OF REFERRAL: _____

Referral Source Information

Agency/Individual Name: _____ Phone #: _____

Address: _____ Fax #: _____

EMAIL ADDRESS: _____

Signature of Referring Therapist (PRP only) _____ Date_____

Location: ☐ **5438 York Rd, Suite 202, Baltimore, MD 21212 Phone: 443-873-7197 Fax: 443-873-7198**
☐

Client Information

Client Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Parent/ Legal Guardian Name: _____ Foster Parent: ☐Yes ☐ No (if yes submit copy of court order)

Age: _____ MA #: _____ MCO: _____ Social Security #: _____

Ethnicity: _____ Is there a current or previous substance use? ☐Yes ☐ No If yes, currently in treatment? ☐Yes ☐ No

Home Address: _____ Is the client Homeless? ☐Yes ☐ No

Home Phone: _____ Alternate Phone: _____ email address: _____

Services Requested

☐ Mental Health Evaluation/Assessment	☐ Psychiatric Rehabilitation Services/ PRP **(complete side 2)**
☐ Individual Therapy	☐ Psychiatric Services
☐ Group Therapy	☐
☐ Family Therapy	☐

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC)

_____

_____

_____

Is the client currently on psychotropic medications? _____yes _____no
If yes, please list all medications_____

- Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: ☐Yes ☐ No (If yes, have they provided a copy of the aftercare plan?) : ☐Yes ☐ No
- Has the client been arrested in the past six months? : ☐Yes ☐ No If Yes, How many times? _____
- Is the client a veteran? : ☐Yes ☐ No
- Currently enrolled in educational program? ☐Yes ☐ No **Highest Grade Completed** _____ School Name : _____
- Currently Employed? ☐Yes ☐ No

Office Use Only

Insurance Authorization Number_____ Number of Auth. Visits:_____

Dates of Authorization From: _____ To: _____

Scheduled Diagnostic Interview ☐ Yes ☐ No Date: _____ Therapist: _____

Immunization Record Request ☐ Yes ☐ No Date: _____

Date Assigned/Comments:_____