**Referral/Request for Services**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Last Name:** | | | |  | | | | | | | | | | **First Name:** | | | | |  | | | | | | | | | | | **Middle Initial:** | | | | |  |
| **Preferred Name:** | | | | | |  | | | | | | | | | **Date of Birth:** | | | | | | | | |  | | | | | **Age:** | | | | |  | |
| **Gender:** | |  | | | | | | | **Ethnicity:** | | | |  | | | | | | | | | **Preferred Language:** | | | | | | | | |  | | | | |
| **Street Address:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | **Apt #:** | | |  | | |
| **City:** |  | | | | | | | | | | | | | | | **State:** | | | |  | | | | | | | | **Zip Code:** | | | |  | | | |
| **Legal Guardian:** | | | | |  | | | | | | | | | | | | **Telephone #:** | | | | | | | |  | | | | | | | | | | |
| **Describe reason for service request:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please specify area(s) of concern:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Housing Needs (Utilities/Rent).** | | | | | | | | | | | **Family Interaction Problems.** | | | | | | | | | | | | | | | | **At Risk–Residential Placement** | | | | | | | | |
| **Academic Problems.** | | | | | | | | | | | **Parenting Issues.** | | | | | | | | | | | | | | | | **Juvenile Delinquency** | | | | | | | | |
| **Medical Problems.** | | | | | | | | | | | **Sexual Abuse / Physical Abuse** | | | | | | | | | | | | | | | | **Truancy** | | | | | | | | |
| **Need of Mental Health Services.** | | | | | | | | | | | **Financial Limitations.** | | | | | | | | | | | | | | | | **Substance Use/Abuse** | | | | | | | | |
| **Social Skills / Peer Relations** | | | | | | | | | | | **Medication Noncompliance.** | | | | | | | | | | | | | | | | **Other:** | | | | | | | | |
| **Please specify current symptoms:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Physical Aggression** |  | **Tantrums** |  | **Noncompliant** |  | **Disruptive** | | **Verbal Aggression** |  | **Stealing** |  | **Lying** |  | **Impulsive** | | **Property Destruction** |  | **Depressed** |  | **Hyperactive** |  | **Anxiety** | | **Sleeping Problems** |  | **Eating Problems** |  | **Homicidal Ideations** |  | **Suicidal Ideations** |   **Has the individual been hospitalized within the last 12 months?  Yes  No** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are requested services mandated by court order?  Yes  x No** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referring Entity/Agency:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | |  | | | | | | | | | | | | | | | **Fax:** | | | | |  | | | | | | | | | | | | |
| **Person Making Referral/Title:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | |  | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | |  | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |
| *For office use only:*  **Disposition: Assigned Referred to other services:** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | **/    /** | | | | | | |
|  | | | **Signature of Targeted Case Management Supervisor** | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |