Mental Health Services Referral

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❒ Male ❒ Female ❒ Family	School & Grade:	
Services Requested: ❒ Office-Based Outpatient ❒ School/Home Based (if therapist is available)		
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Behavioral Health					
Depression					
ADHD					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

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Payment Information:

Type of Insurance ❒ Medicaid Bayou Health Plan ❒ Medicare ❒ Commercial ❒ Other GROUP #
Signature of referring provider name & phone