ADAPT
BEHAVIORAL SERVICES

Referral Form

VOLUSIA COUNTY SCHOOL REFERRAL

☐Volusia/Flagler/St Johns/Putnam

Fax to (386) 675-6490 or
Email to Ormond@Adapt-FL.com
Call (386) 898-5003 for help

DEMOGRAPHIC INFORMATION

Name: ______________________ Social Security #: ______________
Parents/Caregivers Names: ______________________ Relationship to Client: ______________
Address: ______________________ County: ______________
City/State: ______________________ Zip Code: ______________
Phone: ______________ Phone #2: ______________ Email: ______________
Sex: ☐M ☐F Race: ☐White ☐Black ☐Hisp ☐Asian/Pacific ☐Hatian ☐Bi-Racial Birth Date: ______________ Age: _____
Legal status: ☐Minor in parent/guardian custody ☐Minor in state custody ☐Competent Adult ☐Incompetent Adult
School/Employer: ______________ Caregiver's primary language: ______________ Bilingual needed? ☐yes ☐no

OTHER CURRENT SERVICES

☐No current services
☐Mental Health Counseling: Name/Agency: ______________________ Phone: ______________
☐Psychiatric/Medication: Name/Agency: ______________________ Phone: ______________
☐Other: ______________ Name/Agency: ______________________ Phone: ______________

REFERRAL SOURCE INFORMATION

Referring School:______________________ Referring Person: ______________________

Phone: ______________ Fax: ______________ Email: ______________________ Date: __________

SERVICES REQUESTED: ☐Counseling ☐ABA (Behavior Analysis) ☐Counseling or ABA
AVAILABILITY: ☐Any day/time ☐Preferred days/times: ______________ ☐Only on these days/times: ______________

FUNDING INFORMATION

☐Medicaid #: ______________________ Medicaid Type: ______________________
☐Other Insurance: ______________________ ID #: ______________ Group #: ______________
Insurance Phone/Address: ____
Auth info:____

PROBLEM DESCRIPTION

Please check the client's current behavioral/emotional symptoms (required):

☐Physical Aggression	☐Runaway	☐Tantrums	☐Lying	☐Depressed Affect
☐Verbal Aggression	☐Property Destruction	☐Truancy	☐Sexually Acting Out	☐Anxious Affect
☐Non-Compliance	☐Disruptive Behavior	☐Stealing	☐Self-Injury/Suicidal	☐Toileting Problems
☐**Language delayed***	☐**Developmental disability***	☐**Autistic/ASD***	☐Alcohol/Drug Problem	☐Self-Care Problems

*Describe cognitive/language delay *(ex: no language delays, nonverbal, 1-2 word sentences, functions like 3-year-old)*:

Other symptoms or further information:

FOR OFFICE USE ONLY:
Clinician Assigned: ______________________ **Date Assigned:** __________ **Licensed Evaluator:**

Updated 06/19