**Children's Home Society of Florida**
**Referral Form**

Send Referrals to: CHSCLINICAL_NCO@chsfl.org or Fax: (386) 274-0447
Office: (386) 274-0341 ext 226
Supervisor Cell: Cell: 386-871-7391

Date:_____

Type of Service Requested:☐TCM ☐Clinic Counseling ☐ In-Home Counseling ☐In-School Counseling

**Referral Source Information (If not parent/client making referral)**

Person Making Referral: _____ _____
Relationship/Agency: _____ _____
Contact Information-Address: _____
_____
Telephone #: _____ Email: _____

**Client/Family Information**

Client Name: _____ _____ SS#: ___

Address: _____

DOB:_____ Age: _____ Gender: _____ Language: ☐English ☐Spanish ☐Creole ☐Other: _____

Address: _____
_____ County: _____
Phone #: _____ (home) _____ (work) _____ (other)
Email:_____

**If client is a minor, who has authority to consent to treatment?**
Name: _____

Relationship to child:☐ Parent ☐ Relative ☐ Foster Parent ☐ Case Manager ☐Other:_____

School: _____ Grade: _____ Education: ☐ SED ☐ EH ☐ SLD ☐ EMH ☐ TMH ☐ VE

**Client's Presenting Issues**

Behaviors at Home:_____
_____

Behaviors at School: _____
n/a_____

Other symptoms/issues to be treated:_____

Any other pertinent information?_____

Current Psychotropic Medications:_____

Currently Receiving other services? ☐**N** ☐**Y** If yes, what type and where?_____

**Payer Information**

Medicaid? ☐**N** ☐**Y** If yes, Medicaid #: _____

Medicaid HMO:_____

# Children's Home Society of Florida
# Referral Form

Send Referrals to: CHSCLINICAL_NCO@chsfl.org or Fax: (386) 274-0447
Office: (386) 274-0341 ext 226
Supervisor Cell: Cell: 386-871-7391

☐Self pay ☐Other (specify):_____

***Office Use only***

Date Referral Received in Office:_____
Insurance/Eligibility verified by: _____ Date: _____
****Attach MevsNet printout****
Name of HMO: _____ HMO Policy #: _____
Authorizations received: ☐Yes ☐ No Date_____
****Attach copy of HMO authorization form****

Level of Need: ☐ Emergent (Life Threatening) ☐ Urgent ☐ Routine ☐ Court Ordered

*****When scheduling the 1st appointment for the client be sure to screen for the need of Auxiliary Aids and Services so that appropriate aid(s) for the client or their companion can be arranged in time for the scheduled appointment. Each participant in services needs to be screened*****

**Screening/Intake/Referral Questions:**

**1.** Are you disabled? ☐ yes ☐ no

**2.** Are you or any family members who will be involved in receiving services:

☐ Deaf or Hard-of-Hearing ☐ Visually Impaired ☐ Limited English Proficient ☐ None of these

**3.** Do you or any family members who will be involved in receiving services need any assistance with communication?

☐ yes ☐ no

**3.a**. If yes, who needs the assistance?

Name: _____ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____ Relationship to client: ☐Client/consumer ☐ Companion

**3.b**. If yes, what type of assistance are you requesting for each person?

**NOTE:** Staff are NOT to read this list to clients/companions, but are to use it as a checklist to capture the type of assistance that the client/companion is requesting.

☐Sign Language Interpreter, Language: _____
☐Video Relay Interpreter
☐Foreign Language Interpreter, Language: _____

**Information in the following Format(s)**
☐On CD or floppy disk
☐ Audiotape
☐Braille
☐Large Print

**Please request as many as possible of the following documents to be provided in order to assist in the initial assessment.**

☐ Latest Case Plan ☐ Latest Judicial Review ☐ Psychological Evaluations ☐ Comprehensive Assessment Court Orders

## Communication Log

| Date | Action (i.e. phone calls, collateral contacts, appointments scheduled/cancelled, etc.) |
|---|---|
| | |

# Children's Home Society of Florida
# Referral Form

Send Referrals to: CHSCLINICAL_NCO@chsfl.org or Fax: (386) 274-0447
Office: (386) 274-0341 ext 226
Supervisor Cell: Cell: 386-871-7391

| | |
|---|---|
| | |
| | |