

INTERCEPT YOUTH SERVICES, INC.
Mental Health Support

REFERRAL FORM

Identifying Information	
Referral Date:	DOB:
Client Name:	SS#
Address:	Race:
Parent/Legal Guardian	Phone:
Referring Agent:	Phone:
Address:	E-Mail:

Medicaid Information		
Medicaid # (12 digits)		
Recipient Eligible: <input type="checkbox"/> yes <input type="checkbox"/> no		
Service weeks available:		
Date Verified		
Clinical Screening		
<input type="checkbox"/> Danger to Self/Others	<input type="checkbox"/> Hospitalization Hx	<input type="checkbox"/> Depression/Sadness
<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Outpatient Tx	<input type="checkbox"/> Legal Involvement
<input type="checkbox"/> Sexually Inappropriate	<input type="checkbox"/> Suicide Attempts	<input type="checkbox"/> Bereavement Issues
<input type="checkbox"/> Peer-Relationship Problems	<input type="checkbox"/> Client Substance Abuse	<input type="checkbox"/> Victim Physical/Emotional Abuse
<input type="checkbox"/> Parent/Child Problems	<input type="checkbox"/> Eating/Sleeping Disturbance	<input type="checkbox"/> Victim Sexual Abuse/Molestation
<input type="checkbox"/> Truancy Issues	<input type="checkbox"/> Anxiety/Phobias	<input type="checkbox"/> Other: _____

Reason for Referral:			
If available, please provide copies of:			
<input type="checkbox"/> Social History	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Legal History	<input type="checkbox"/> Current Physical Exam

Prescreen Completed By: _____

Date: _____

IYS Clinical Supervisor/Reviewer: _____ Date:

Approved Denied