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**MENTAL HEALTH REFERRAL FORM**

**Date of Referral:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Client** **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT DEMOGRAPHIC INFORMATION**

Client Name: D.O.B.: Age:

Male [ ]  Female [ ]  SS#: Race:

Employment Status: Marital Status: Phone#:

Current Address:

City/State: Zip:

**PARENT/GUARDIAN INFORMATION *(if applicable)***

Parent/Guardian Name: (Relationship to client):

Address: City/State: Zip:

Cell Phone# Alt. #:

**INSURANCE INFORMATION**

Primary Insurance: ID#: Effective Date:

Policy Holder: [ ]  Self [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Contact#:

Auth. /Eligibility Verified By: Date:

**\*IF CLIENT IS UNDER DSS GUARDIANSHIP, PLEASE COMPLETE THE INFORMATION BELOW**

Social Workers Name:

Address: City/State: Zip:

Work#: Cell#: Fax#:

Consent Attached? [ ] Yes [ ] No

**PRIMARY CARE PHYSICIAN INFORMATION**

Name: Office Phone:

Address/City/State/Zip: Office Fax:

**MEDICAL HISTORY & INFORMATION**

Is The Client Currently Receiving Mental Health Services? [ ]  Yes [ ]  No

Therapist Name, Facility & Contact#:

Psychiatrist Name, Facility & Contact#:

Are You Planning On Discontinuing Services With These Providers? [ ]  Yes [ ]  No If yes, reason

Is The Client On Any Psychiatric Medication? [ ]  Yes [ ]  No

If yes, Name of Medication(s)

Are Medications Prescribed By Psychiatrist or Primary Care Doctor?

Any History Of Substance Abuse? [ ]  Yes [ ]  No If Yes, Is Substance Use Active Or In Remission:

Any History Of Being Diagnosed With A Developmental Disorder? [ ]  Yes [ ] No

If Yes, Please Indicate If Client Can Communicate Verbally: [ ]  Yes [ ] No

Please Give A Brief History Of Current Mental Health Concerns:

|  |
| --- |
| **Referred By** (*Name and phone number of* *person completing the form*): |