 ***3100 Lord Baltimore Drive, Suites 208-209 § Windsor Mill, MD 21244***

***(Office) 410-701-7384 ♦ (Fax) 410-521-7005***

***Email: messages@hclff.com ♦ Website: www.hclff.com***

**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*): |