# CORE & IFI PROGRAMS

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| Referral Form | | |
| **Name:** | | **Referral Date:** |
| Address: | | **Client’s SSN:** |
|  | | **Referral Name:**  Number:  Fax:  **Email:** |
| County: | |
| **Phone:**  Cell: | |
| Ethnicity:  Country of Birth: | **Gender:** \_\_M \_\_F | **Date of Birth:** |
| Additional Contact(s) | | |
| Parent/Guardian/Representative: Phone:  Address: Email: | | |
| Insurance Information | | |
| **Insurance Name:** | | **Primary Insurance Holder:** |
| **Policy #:** | | **Primary SSN:** |
| **Group #:** | | **Primary Address:** |
| **Ins. Co. Phone #:** | | **Address:** |
| **Name of Ins. Plan:** | | |
| Medical Information | | |
| Allergies: Allergies: (Y) or (N) *If yes specify:* | | Seizures: (Y) or (N) *If yes specify:* |
| **PCP Name:** | | **PCP Address:** |
| **PCP Phone Number:** | |  |
| **Present Prescribed Meds/Dosage/Frequency:** | | |
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| **Behavioral Health History:** What are the last three places that you ever received Behavioral Health Services and/or Substance Abuse Services? | | |
| 1. | | 2. |
| 3. | | |
| **Diagnosis:** | | |
| 1. Primary 2. Secondary 3. Other | | |
| **Judge Name (If Applicable):** | | |
| Name Number: | | |
| **Comments** (Current Charges, DAI Score, Reason for Referral, Etc**):** | | |
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**Please fax this form to (678) 892-8575 or call (678) 344-7836 if there are any questions.**

**OFFICE USE ONLY**

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| Date Received |  | Date Assigned |  |