Screening and Referral Source Information:

Agency making the Referral: _____ Time:_____ Date:___/___/____
Person making the Referral : _____ Phone:(___)_____-_____
Address:_____ City/State/Zip:_____ ___ _____

CLIENT INFORMATION:

Legal Client Name:_____ Address:_____
City:_____ County:_____ State:_____ Zip:_____
Home/Facility/School Phone:(___)___-_____ Work:(___)____-____ Other:(___)____-_____
Male Female Race:_____ Age:___ DOB:___/___/_____ SSN:_____-_____-_____
Marital Status: Single Married Divorced Widowed
Responsible Party:_____ Relationship to Client: Parent Guardian Durable Power of Attorney
Other_____

Emergency Contact:
Name:_____ Phone:(___)___-_____ Relationship:_____
Address:_____ City/State/Zip:_____ ___ _____

Medicare#:_____ Medicaid#:_____ Medigap#:_____

Other Payment Source:_____ Address:_____
Prior Authorization Required:_____ City/State/Zip:_____ ___ _____
Special Billing Instructions:_____ Phone:(___)___-_____ ID#:_____

Primary Care Physician:_____ Phone:(___)____-_____ Date last seen:_____
Psychiatrist:_____ Phone:(___)____-_____ Date last seen:_____

PRESENTING PROBLEM:

Anxiety Depression Substance Abuse Psychosis Family Problems Aggressive Behavior
Assaultive Verbally Threatening Homicidal Threats Suicide Threats Suicide Attempts
Comments:_____
_____
_____
_____

SCREENING REFERRAL OUT COME(Completed by Chrysalis)

Ineligible(Reason):_____
_____
Referredto:_____
_____
If accepted: Eligibility Checked and Attached: YES NO
Clinician Assigned:_____ Date:_____
Date Intake Completed:_____
Primary Axis I Dx Code:_____
Referral Source Contacted:_____ Date:_____ Time:_____