

# STEP BY STEP CARE, INC.

## REFERRAL FORM

**\*\*Instructions:** This form is to be completed from the initial contact from the Intake Coordinator or others coordinating services for the consumer. Any additional information such as Psychological, developmental, functional evaluations which may be helpful in the treatment of the client through the services of this agency will be requested from the party coordinating services.

Date of Contact: \_\_\_\_\_ LME/Agency: \_\_\_\_\_ County: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Legally Responsible Party: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone #1: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Diagnosis (Please include codes): \_\_\_\_\_

Services requested: \_\_\_\_\_ Date of Assessments: \_\_\_\_\_

Staff preferences: \_\_\_\_\_ Name of Current Therapist: \_\_\_\_\_

Current School: \_\_\_\_\_ Current Grade: \_\_\_\_\_ School Problems? \_\_\_\_\_

Medicaid Number \_\_\_\_\_ Current Medicaid? \_\_\_\_\_

Other Insurance? \_\_\_\_\_ Policy Number: \_\_\_\_\_

Is consumer currently receiving any services with another provider, if so who? \_\_\_\_\_

Is consumer taking any medications? If so, please provide the names and dosages. \_\_\_\_\_

Reason(s) for admission/outcomes: \_\_\_\_\_

Client Strengths: \_\_\_\_\_

Client Preferences: \_\_\_\_\_

Behavioral: \_\_\_\_\_

Medical Concerns/ Mental Status: \_\_\_\_\_

Social/Family History: \_\_\_\_\_

Does this client have a behavior plan? \_\_\_\_\_

Is this client in need of a psychological evaluation for a behavior plan? \_\_\_\_\_