**Solutions For Life**

*Your Partner in Mental Health & Substance Abuse Treatment*

# *INTERAGENCY REFERRAL ~ REQUEST FOR SERVICES*

Date of Request/Referral: ______________________ Interviewer: ____________________ Douglas Glenrock Lusk

Caller's Name: ________________________________ Caller's Phone #: ______________________________

Client's Legal Name: ______________________________ SS#: ____________________ DOB: __________________
(First, Middle Initial, Last)

Mailing Address: ____________________________________________________________________
Street Address or PO Box, City State, Zip **(P.O.Box if Lusk or Glenrock)**

Physical Address (if different): ________________________________________________________
Street Address or PO Box, City State, Zip

Client Phone #: ____________________ Client Referral Source: ________________________________

Client's Legal Guardian: __________________________ Relationship to client: _________________________

Does the client have type of medical/health insurance? **Medicaid (Title 19, Equality Care)** **Medicare** **Commercial** **None**
**(Fill out back of form if insurance information is available)**

**Prior MH/SA Services (date):** ______________________________ **If yes, where:** ______________________

**Reason for Seeking Services**: (to assess and schedule according to therapist specialty and priority) ______________________

______________________________________________________________________________

**Risk Assessment**: (history of or potential for suicide attempt; is client a threat to self or others? etc.): ____________________

______________________________________________________________________________

**Substance Abuse or use**: (if applicable): __________________________________________________

Are you court ordered? (Please circle) Yes No IV Drug Use? (Please circle) YES NO

If yes, please bring court paper-work. Is client currently under (Please Circle): Supervised or Unsupervised Probation?

If client is on supervised probation who is probation officer? _________________________________________

Is client a veteran? (Please circle) Yes No if yes, bring copy of DD214 to first scheduled appointment

Is client pregnant? (Please circle) Yes No (Required by Federal Statutes for assigning priority status)

Client's primary care provider: ______________________________ phone number: ________________

All medications client is currently taking (name of medication, dosage, and prescriber): ______________________

______________________________________________________________________________

______________________________________________________________________________

**Per Client they need to be seen:** **Email address:** ______________________________

_____ Crisis priority (needs to be seen immediately)
_____ High priority (needs to be seen within 72 hours)
_____ Medium to low priority (needs to be seen within 7 days)

FOR OFFICE USE ONLY

| Remind client to bring:<br>Proof of Insurance – Ins. Card/Medicaid/Medicare Card<br>Intake Fee - $20 minimum (Medicaid: no fee) | Client accepted initial appointment: YES or NO<br>If No why: |
|---|---|
| Appt. Date & Time: | Clinician: |

**Reason unable to provide services:**

______________________________________________________________________

**Contact Log:**

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