

**FAMILY SOLUTIONS**  
**REFERRAL FOR MENTAL HEALTH SERVICES**



**Client Information:**

Name:	Date of Birth:
Race/Ethnicity:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
School & Grade:	
Services Requested: <input type="checkbox"/> Office-Based Outpatient <input type="checkbox"/> Head Start/School Based (if therapist is available)	
Preferred Service Location: <input type="checkbox"/> Greensboro Office <input type="checkbox"/> Archdale/HP Office <input type="checkbox"/> Childcare Center/School: _____	

**Parent or Legal Guardian Information:**

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: <input type="checkbox"/> Home <input type="checkbox"/> Group Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Other (specify):

**Payment Information:**

Type of Insurance: <input type="checkbox"/> Medicaid, What county? <input type="checkbox"/> Healthchoice <input type="checkbox"/> Other:
Insurance ID #:

**Referral Source Information:** Complete this section so we can contact you after the referral is made.

Name:	Mailing Address:
Phone #:	Email Address:
How did you hear about Family Solutions?	

**Child/Adult Mental Health Information:**

Current Medication:	Current DSM-IV Diagnosis:
Drug Name	Axis I:
	Axis II:
	Axis III:
	Axis IV:
Prescribing Physician Name & Phone #:	Axis V:
	Diagnosing Professional's Name & Phone #:

<b>Current Mental Health Symptoms:</b>	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to parents / those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

**Reason for referral for treatment:** In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

**Desired treatment outcomes:** In your own words, describe the results you want for the child/adult from receiving mental health services.

**Additional Comments or Information Regarding this Referral:**

**PLEASE FAX COMPLETED REFERRAL FORM BACK TO (336) 899-8811. IF YOU HAVE NOT HEARD BACK FROM US WITHIN 2 BUSINESS DAYS, PLEASE CALL OUR INTAKE TEAM @ (336) 899-8800 EXT. 8.**