May You Find Peace, LLC

HOLISTIC THERAPEUTIC SERVICES

REFERRAL FACE SHEET

DATE_____

REFERRAL SOURCE (AGENCY) _____

(CONTACT PERSON)_____ RELATIONSHIP TO CLIENT_____

ADDRESS_____

PHONE_____CELL PH _____EMAIL ADDRESS_____

CLIENT'S NAME_____ DOB_____ SEX _____ RACE _____

MARITAL STATUS _____NAME OF PRIMARY CARE PHYSICIAN _____

SOC. SEC.**#**____/____/_____**TYPE OF INSURANCE**_____**INSURANCE NO**._____

DOES CLIENT HAVE ANY OTHER TYPE OF INSURANCE? YES/NO

ADDRESS_____

HOME PH(____)_____ WORK PH(____)_____ CELL PH.(____)_____

LIVING SITUATION: __ PRIVATE HOME __ FOSTER CARE __ HOMELESS ___ GROUP HOME ___ ROOMING HOUSE

EMPLOYMENT STATUS: __ FULLTIME __ PART TIME __ UNEMPLOYED __ SEEKING WORK __ STUDENT

HAS CLIENT ATTENDED SCHOOL IN THE LAST 3 MONTHS? _____ IF YES, WHAT GRADE IS CLIENT CURRENTLY IN? _____

IF NO, WHAT IS THE HIGHEST GRADE COMPLETED? _____

HAS CLIENT BEEN ARRESTED IN THE LAST 30 DAYS? _____ IF YES, HOW MANY TIMES? _____

HAS CLIENT RECEIVED OTHER LEVELS OF CARE? PLEASE CHECK ALL THAT APPLY

□ PRP □ PHP □ OTHER _____

IS CLIENT CURRENTLY RECEIVING ADDITIONAL SUPPORTIVE SERVICES? _____PLEASE LIST: _____

PARENT/GUARDIAN/OTHER_____

HOME PH(____)_____ WORK PH(____)_____CELL PH.(____)_____

SERVICE REQUESTED (CHECK ALL THAT APPLY)

□ PRP □ TBS □ OTHER _____

DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET OF PAPER IF NECESSARY. PLEASE INDICATE IF CLIENT IS RECEIVING SERVICES ELSEWHERE AND THE SCOPE OF THOSE SERVICES. PROVIDE CONTACT INFORMATION FOR THOSE SERVICE PROVIDERS. PLEASE INDICATE THE STATUS OF OTHER SERVICES AND IF CLIENT WAS DISCHARGED FROM THOSE SERVICES WHAT THE REASON FOR DISCHARGE WAS AND PROGNOSIS UPON DISCHARGE. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS (MUST HAVE BEEN COMPLETED WITHIN THE LAST 6 MONTHS), ETC.)

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