Children's Home Society of Florida
Referral Form

Send Referrals to: CHSCLINICAL_NCO@chsfl.org or Fax: 386-304-7620
Call: 386-304-7600 ex. 226

Date:_____________________________
Type of Service Requested:☐TCM ☐Clinic Counseling ☐ In-Home Counseling ☐In-School Counseling

Referral Source Information (If not parent/client making referral)

Person Making Referral: __________ ____
Relationship/Agency: _______ ____
Contact Information-Address: ____
____
Telephone #: ____________________ Email: ______________________________

Client/Family Information

Client Name: _____ ___________________________ SS#: ___

Address: ____

DOB:_______________ Age: ________ Gender: ___________ Language: ☐English ☐Spanish ☐Creole ☐Other: _____________

Address: ____
____ County: ______________________
Phone #: ______________________ (home) _______________________ (work) ________________________ (other)
Email:____
If client is a minor, who has authority to consent to treatment?
Name: ____

Relationship to child:☐ Parent ☐ Relative ☐ Foster Parent ☐ Case Manager ☐Other:______________________

School: ______________________________ Grade: _______ Education: ☐ SED ☐ EH ☐ SLD ☐ EMH ☐ TMH ☐ VE

Client's Presenting Issues

Behaviors at Home:_____
____

Behaviors at School: ___________
n/a____

Other symptoms/issues to be treated:____

Any other pertinent information?____

Current Psychotropic Medications:____

Currently Receiving other services? ☐**N** ☐**Y** If yes, what type and where?______________________________

Payer Information

Medicaid? ☐**N** ☐**Y** If yes, Medicaid #: ______________________________

Medicaid HMO:____

☐Self pay ☐Other (specify):____

Office Use only

Children's Home Society of Florida, North Coastal Division Clinical Services 386.304-7600 ex. 226

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Date Referral Received in Office:___________________________
Insurance/Eligibility verified by: _______________________________ Date: ___________________
Attach MevsNet printout
Name of HMO: ______________________________________ HMO Policy #: _____________________________
Authorizations received: ☐Yes ☐ No Date___________________________
Attach copy of HMO authorization form

Level of Need: ☐ Emergent (Life Threatening) ☐ Urgent ☐ Routine ☐ Court Ordered

*****When scheduling the 1st appointment for the client be sure to screen for the need of Auxiliary Aids and Services so that appropriate aid(s) for the client or their companion can be arranged in time for the scheduled appointment. Each participant in services needs to be screened*****

Screening/Intake/Referral Questions:

1. Are you disabled? ☐ yes ☐ no

2. Are you or any family members who will be involved in receiving services:

☐ Deaf or Hard-of-Hearing ☐ Visually Impaired ☐ Limited English Proficient ☐ None of these

3. Do you or any family members who will be involved in receiving services need any assistance with communication?

☐ yes ☐ no

3.a. If yes, who needs the assistance?

Name: _____________________________________ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____________________________________ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____________________________________ Relationship to client: ☐Client/consumer ☐ Companion
Name: _____________________________________ Relationship to client: ☐Client/consumer ☐ Companion

3.b. If yes, what type of assistance are you requesting for each person?

NOTE: Staff are NOT to read this list to clients/companions, but are to use it as a checklist to capture the type of assistance that the client/companion is requesting.

☐Sign Language Interpreter, Language: _______________
☐Video Relay Interpreter
☐Foreign Language Interpreter, Language: _______________

Information in the following Format(s)
☐On CD or floppy disk
☐ Audiotape
☐Braille
☐Large Print

Please request as many as possible of the following documents to be provided in order to assist in the initial assessment.

☐ Latest Case Plan ☐ Latest Judicial Review ☐ Psychological Evaluations ☐ Comprehensive Assessment Court Orders

Communication Log

Date	**Action** (i.e. phone calls, collateral contacts, appointments scheduled/cancelled, etc.)

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