HANDS ACROSS BALTIMORE

Client Referral Form

DATE

NAME | **DATE OF BIRTH** | **SOCIAL SECURITY #**

ADDRESS

HOME PHONE | **LEAVE MESSAGES:** | **CELL PHONE** | **LEAVE MESSAGES:**

AGE | **SCHOOL** | **GRADE**

WORK:

MARTIAL STATUS

NAME OF SPOUSE/OTHER (IF APPLICABLE): | **TELEPHONE** | **LEAVE MESSAGES:**

WHERE DOES THE CHILD CURRENTLY RESIDE?

PARENT /GUARDIAN'S NAME | **RELATIONSHIP:**

CURRENT ADDRESS | **TELEPHONE**

PARENT /GUARDIAN'S NAME | **RELATIONSHIP:**

CURRENT ADDRESS | **TELEPHONE**

1. TYPE OF INSURANCE:

HANDS ACROSS BALTIMORE

INSURANCE NAME:

POLICY/MEMBER ID

GROUP #

PRIMARY CARD HOLDER'S NAME:

DATE OF BIRTH

SOCIAL SECURITY #

RELATIONSHIP TO PRIMARY CARD HOLDER:

2. TYPE OF INSURANCE:

INSURANCE NAME:

POLICY/MEMBER ID

GROUP #

PRIMARY CARD HOLDER'S NAME:

DATE OF BIRTH

SOCIAL SECURITY #

RELATIONSHIP TO PRIMARY CARD HOLDER:

REFERRED BY:

TITLE:

TELEPHONE:

FACILITY/OFFICE NAME:

ADDRESS:

EMAIL

FAX

SERVICE(S) REQUESTING:

IF EVALUATION, NEED BY?

PREFERRED LOCATION:

BRIEF SUMMARY OF YOUR CONCERNS:

IF EVALUATION, DATE NEEDED BY?

COURT ORDERED?

COURT DATE?

BY WHOM?

HANDS ACROSS BALTIMORE

PREVIOUS BEHAVIORAL/MENTAL HEALTH TREATMENT?

WHERE:

FOR WHAT?

WHAT WAS THE DIAGNOSIS /OUTCOME?