REFERRAL FORM

PROGRAMS:

Outpatient Therapy (Individual, family): ☐ Case Management: ☐ Psychosocial Rehabilitation (PSR): ☐ Psychiatric: ☐

Person Referred First Name: _____ Last Name: _____

DOB: _____ SSN: _____ Gender: _____

Reason for Referral: _____

Has Person Referred Received Services from Chrysalis Before? _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone#: _____ Email Address: _____

Legal Guardian: _____ Relationship to Person Referred: _____

Address _____ City _____ State _____ Zip Code _____ County _____

Legal Guardian Preferred Phone#: _____ Other Phone#: _____

Additional Contact: _____ Relationship to Person Referred: _____

Additional Contact Preferred Phone#: _____ Other Phone#: _____

Is Person Referred in School? _____ If yes, Name of School: _____

Is Person Referred Residing in Group or Therapeutic Foster Care? _____ If yes, with Whom: _____

Is Person Referred Currently Receiving Therapeutic Services? _____ If yes, with Whom: _____

Has person been hospitalized in past 7 days? _____

Preferred Language for Assessment: _____ Preferred Language for Services: _____

Limited English Proficiency ☐ Yes ☐ No ☐ Visually Impaired

☐ Hearing Impaired Auxiliary Communication Aids desired: _____

Race: ☐ White Hispanic ☐ American Indian ☐ Asian or Pacific Islander ☐ Other

☐ African American ☐ Multi-Racial ☐ Hispanic of African American Descent ☐ White

Ethnicity: ☐ Puerto Rican ☐ Cuban ☐ Mexican ☐ Other Hispanic ☐ Haitian ☐ Other

Where would services be rendered ? ☐ Home ☐ School ☐ Office ☐ Telehealth

Insurance/Funding: _____ Policy/Member ID: _____

Referral Source-Agency: _____

Name: _____ Title/Position: _____

Phone#: _____ Email: _____

If Self Referred, How Did You Hear About Us? _____