A D A P T
BEHAVIORAL SERVICES

Referral Form

☐Orange/Seminole/Lake
Fax to (407) 699-0444 or
Email to Maitland@Adapt-FL.com
Call (407) 622-0444 for help

☐Osceola/Polk
Fax to (407) 518-0808 or
Email to Kissimmee@Adapt-FL.com
Call (407) 928-0444 for help

☐Volusia/Flagler/St Johns/Putnam
Fax to (386) 675-6490 or
Email to Ormond@Adapt-FL.com
Call (386) 898-5003 for help

DEMOGRAPHIC INFORMATION

Name: _____ Social Security #: _____

Parents/Caregivers Names: _____ Relationship to Client: _____

Address: _____ County: _____

City/State: _____ Zip Code: _____

Phone: _____ Phone #2: _____ Email: _____

Sex: ☐M ☐F Race: ☐White ☐Black ☐Hisp ☐Asian/Pacific ☐Hatian ☐Bi-Racial Birth Date: _____ Age: ____

Legal status: ☐Minor in parent/guardian custody ☐Minor in state custody ☐Competent Adult ☐Incompetent Adult

School/Employer: _____ Caregiver's primary language: _____ Bilingual needed? ☐yes ☐no

OTHER CURRENT SERVICES

☐No current services

☐Mental Health Counseling: Name/Agency: _____ Phone: _____

☐Psychiatric/Medication: Name/Agency: _____ Phone: _____

☐Other: _____ Name/Agency: _____ Phone: _____

REFERRAL SOURCE INFORMATION

Referring Agency: _____ Referring Person: _____

Phone: _____ Fax: _____ Email: _____ Date: _____

SERVICES REQUESTED: ☐Counseling ☐ABA ☐Counseling or ABA ☐Case Management

AVAILABILITY: ☐Any day/time ☐Preferred days/times: _____ ☐Only on these days/times: _____

FUNDING INFORMATION

☐Medicaid #: _____ Medicaid Type: _____

☐Other Insurance: _____ ID #: _____ Group #: _____

Insurance Phone/Address: _____

Auth info: _____

PROBLEM DESCRIPTION

Please check the client's current behavioral/emotional symptoms (required):

☐Physical Aggression	☐Runaway	☐Tantrums	☐Lying	☐Depressed Affect
☐Verbal Aggression	☐Property Destruction	☐Truancy	☐Sexually Acting Out	☐Anxious Affect
☐Non-Compliance	☐Disruptive Behavior	☐Stealing	☐Self-Injury/Suicidal	☐Toileting Problems
☐Language delayed*	☐Developmental disability*	☐Autistic/ASD*	☐Alcohol/Drug Problem	☐Self-Care Problems

Describe cognitive/language delays below (ex: no language delays, nonverbal, 1-2 word sentences, functions like 3-year-old)

Other symptoms or further information:

TCM referrals: ☐DCF/CBC-involved ☐DJJ-involved ☐Recent Baker Act/residential ☐Chronic MH (adult) **OR**

Needs help to link with other resources (check all that apply)

☐Other therapies (OT/PT/Speech) ☐Housing ☐Mentor ☐Tutor ☐Employment (adult) ☐Support system (adult)

☐Therapy for parent/other relative ☐Medical ☐Dental ☐Transportation ☐Other: _____

FOR OFFICE USE ONLY:
Clinician Assigned: _____ **Date Assigned:** _____ **Licensed Evaluator:**

Updated 08/17