CHRYSALIS HEALTH
REFERRAL FORM

Program requested:

☐ Outpatient Therapy (Individual or Family) ☐ Case Management ☐ Psychiatric

Name of person being referred: First Name _____ Last Name _____

Date of birth _____ **SSN#** _____ **Gender** _____

Reason for Referral: _____

Is person referred residing in group or therapeutic foster care? ☐ Yes ☐ No If yes, where? _____

Preferred language for assessments: _____

Preferred language for services: _____

Limited English proficiency? ☐ Yes ☐ No

Where would you prefer services take place? (based on availability) ☐ Home ☐ School ☐ Office ☐ Telehealth

Race

☐ White Hispanic ☐ American Indian ☐ Asian or Pacific Islander ☐ White
☐ African American ☐ Multi-Racial ☐ Hispanic of African Descent ☐ Other

Ethnicity

☐ Puerto Rican ☐ Cuban ☐ Mexican ☐ Haitian ☐ Other

Address _____ _____ _____ _____ _____
Street Address | Street Address Line 2 | City | County | Postal / Zip Code

Preferred phone # _____
Please enter a valid phone number

Additional phone # _____
Please enter a valid phone number

Legal Guardian _____

Relationship to person referred: _____

Email _____ example@example.com

Is person referred currently attending school?

☐ Yes ☐ No

If yes, what school? _____

Additional siblings, name and DOB _____

Additional siblings, name and DOB _____

Additional siblings, name and DOB _____

Has person referred received services from Chrysalis Health before? ☐ Yes ☐ No

Has person been hospitalized in the past 7 years? ☐ Yes ☐ No If yes, which hospital? _____

Referral Source Agency: **Volusia County Schools** Name of person making referral _____

Title/position _____ Phone Number _____ Email _____

Insurance/Funding: _____ Policy/Member ID: _____

If self-referral, how did you hear about us? _____

Name of assigned therapist: _____

Name of Chrysalis Health Community Liaison: _____

Please send completed Referral Form via **Fax: (888) 395-5030** or **Email: Referrals@ChrysalisHealth.com**
Website: **www.chrysalishealth.com** - For questions call **(888) 587-0335**