Outpatient Services Referral

Client Name: **D.O.B:** **SSN:**

Address: **City:** **State:** **Zip:**

Phone Number:

Contact Name (Parent/Guardian if minor):

Parent/Guardians Relationship to Child: ☐Natural parent ☐Relative ☐Foster parent ☐Adoptive Parent ☐Guardian

Insurance Company/MCO: **ID Number:**

Reason for Referral: ☐ OP Mental Health/Therapy Assessment ☐ IOP ☐ DUI Assessment ☐ School Based Services ☐ Targeted Case Management

Name of School that Child attends (If Applicable):

History of Substance Abuse: ☐Yes ☐No ☐Unknown (If no, skip to next section)

Currently using: ☐Yes ☐No ☐Unknown

History of Substance Abuse Treatment: ☐Yes ☐No ☐Unknown

Family Substance Abuse Issues: ☐Yes ☐No ☐Unknown

Please list all know past and current mental health diagnoses: ☐ **Unknown**

Current Diagnosis	Past Diagnosis

Referred by (Print Name):
Agency:
Relationship to Client:
Phone Number:
Please attach any notes or diagnosis that would help expedite services.

Return this Application to:

Regroup
Fax: (606) 547-4180
Email: regroup@rameyestep.com
Call Eva Staggs with any questions
Office: 606-547-4400

For Office Use Only

Referral Date:________________________

TCM Assigned:________________________

Assigned Date:________________________

Outpatient Services Referral

Notes: (If needed)

For Office Use Only

Referral Date:_________________________

TCM Assigned:________________________

Assigned Date:________________________