JOURNEY THROUGH LIFE
HELPING FAMILIES HELP THEMSELVES

Please fax to (832)-431-4247 or Call (832)-431-4246

Community Referral Form

Date: _____

Client Information

Last Name:	First Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Current Address:		Phone/Mobile Number:	
Responsible Party:		Relationship/Role:	

Referral Source

Referral Contact:	Phone Number:	Email:

Financial and Insurance Information

Managed Care Organization (MCO):

☐ Medicaid ☐ Aetna ☐ Amerigroup ☐ Community Health Choice ☐ Molina
☐ Superior ☐ Texas Children's Health Plan ☐ United Healthcare ☐ Unknown

Policy Number:	Group Number:

Symptoms and Behaviors

☐ Anxiety, irritability	☐ Argumentative or uncooperative	☐ Poor School Functioning
☐ Depression	☐ Criminal / Juvenile behavior	☐ Family Concerns / Conflict
☐ Substance abuse	☐ Emotional outbursts	☐ Impulsive / Hyperactive
☐ Aggressive / Disruptive Behavior	☐ Suicidal Ideation	☐ Decline in functioning
☐ Educational Concerns	☐ Low self-esteem	☐ Inappropriate sexual behavior
☐ Sets Fires /Animal abuse	☐ Runaway behaviors	☐ Self-abuse or mutilation
☐ Social isolation	☐ Danger to self or others	☐ Poor decision making
☐ Poor appetite/weight problems	☐ Non-compliant with medical/nurse care	☐ Other (Specify): _____

None Known:

Additional Information

How long has the client had services with you?

Prior Mental Health / Rehabilitation Agency?

Prior Hospitalization?

Safety concerns. ☐ Yes ☐ No

Is there any potential for violence or harm to anyone in the home?

Concerns for physical health or basic needs?