CARTER CLINIC, P.A.

REFERRAL SCREENING FORM

Date: _____ Consumer Name: _____ Age: _____

Gender: M / F DOB: _____ Insurance/Number: _____

Consumer Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Referring Source/ Agency: _____

Referring Source/ Agency Contact: _____ Phone: _____

Parent/Guardian: _____ Parent/Guardian Phone: _____

Reason for Referral:

- ☐ Suicidal/Homicidal Ideation
- ☐ Suspected Drug or Alcohol Use
- ☐ Psychosocial/ Environmental Problems
- ☐ Mood/Adjustment Disorder
- ☐ General Medical Condition
- ☐ Suspected Gang Involvement
- ☐ Behavioral/ Relational Problems
- ☐ Abuse/ Neglect
- ☐ DSS Involvement
- ☐ Other/Unspecified

Describe Concerns:

_____

_____

_____

_____

_____

_____

Service Requested:

- ☐ Mental Health Assessment
- ☐ Psychological Evaluation
- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Medication Management
- ☐ Peer Support
- ☐ SAIOP
- ☐ SACOT

FOR OFFICE USE ONLY:

Date of Contact with Referring Source/Agency: _____

Appt. Date/Time: _____/_____☐ AM ☐PM

Appt. Scheduled With _____

Staff Signature_____