***Client’s Information (Please print clearly):*** Date:

Client’s Name: Sex:

Client’s Address: City:

Zip Code: Race:

SSN: DOB:

School: Grade: ESE:

Current Mental Health Diagnosis:

Parent/Guardian: Contact Number:

Email: Other contact:

***Please list insurance coverage for the client being referred:***

Amerigroup \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CMS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staywell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Magellan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunshine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Molina\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prestige\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_United Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please circle behavior symptoms exhibited by youth: (Please circle all that apply)***

Non-Compliance: Physical Aggression: Verbal Aggression: Lying:

Disruptive Behavior: Tantrum Behavior: Sleep Disturbance: Runaway Behavior:

Stealing: Eating Disorder: Property Destruction: Depressed Mood: Poor School Grades

Inappropriate Sexual Behavior; Self – Injury: Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Services Desired: (Please circle)***

Individual Counseling (In-Home/School) \_\_\_\_\_\_\_ Individual Counseling (Outpatient) \_\_\_\_\_

Group Counseling: Mentoring Tutoring

***Referral Source:***

Name: Agency:

Phone: Fax: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TCM Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Provider #018692300 Units \_\_\_\_\_\_\_

**3700 34th Street Suite 100F\*Orlando, Florida 32805\*(407)431-8831office\*(407)386-8373efax**