LONGWOOD CARE
Empowerment, advocacy, inclusion & collaboration.

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# INTAKE REFERRAL

SERVICES: DATE: _____

☐ In-Home Family Therapy ☐ Outpatient Therapy ☐ Trauma Therapy ☐ Family Stabilization/Specialty Care/Other

## REFERRED PERSON/FAMILY:

Name of Client: _____ Date of Birth: _____ (Minor ☐)

Name of Guardian: _____ Relationship: _____

Who has legal custody?: _____ Physical custody?: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____

Primary Language: _____ Ethnicity (Country of Origin): _____

School: _____ Health Center (PCP): _____

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____ ☐ Choose not to identify

## REFERRAL SOURCE:

Individual's Name: _____ Role with Family/Agency: _____

Phone: _____ Email: _____

## INSURANCE INFORMATION:

Insurance Plan/Provider: _____ MMIS/ID#: _____

Current Diagnosis/Axis I (Code): _____

Who generated diagnosis/when?: _____

## ADDITIONAL INFORMATION:

What are the current concerns/behaviors of the identified client?