Transformation Healthcare INC.

General Referral Form

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Date of Referral: _____

Referring Agency:_____**Phone#:**_____**Contact:** _____

Email of contact: _____

How did you hear about us? _____

Name:_____DOB:_____SS#:_____

Parent/Legal Guardian Name:_____ Gender: M / F / O Marital Status:_____

Address:_____Contact Phone #: _____

Email:_____Emergency Contact: (Name/Phone) _____

Insurance:_____

Medicaid Medicare

MA#_____ Medicare ID: _____

QMB is Medicare - *Medicare ID #'s are 11 digit alpha-numeric*

If Medicare, please complete the following questions below:

Criteria for PRP Uninsured/ State Funded Coverage Questions	Yes	No
Recently Incarcerated?		
Hospitalized for mental health within the last 6 months?		
Placed in a state hospital?		
A RRP (Residential Rehabilitation Service) Bed within the last 6 months?		

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC): _____

Type of Care (PLEASE CHECK ALL THAT APPLY, if qualified):

_____Psychiatry
_____Medication Management
_____Therapy
_____ Residential
_____ PRP Services (If qualifying diagnosis)
_____ Substance Abuse Recovery Treatment
_____ ACT (Mobile Treatment)

Highest level of Education: _____

Any arrest in the past 30 days? Y____ N_____
Currently Employed? Y____N____
Veteran? Y____ N____
In Iraq or Afghanistan? Y____N____
Is the client eligible for MTA pass? Y____N___

Any restrictions from referring agency (i.e., mobile therapy, on blackout, no telemedicine, etc.)? Y____N____

If yes, please explain:_____

Is the client on parole or probation? Y____N____

If so, provide parole/probation officer's name and best contact number?

_____

Office Use Only:

Intake date & time_____Therapist assigned_____Completed by: _____