

Date \_\_\_\_\_

**FAX TO: 816-468-0289**  
**ATTN: CENTRAL SCHEDULING**

**Therapy Services Referral Form**

Referred by \_\_\_\_\_ Title \_\_\_\_\_ Agency \_\_\_\_\_

Services needed \_\_\_\_\_ In-Home \_\_\_\_\_ Outpatient In-Office \_\_\_\_\_

Client Name \_\_\_\_\_ Gender: M F DOB \_\_\_\_\_

Parent/Guardian Name (if minor) \_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Current Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Please indicate all current professional services client is receiving:**

Service	√	Contact Person	Phone Number
Psychiatrist / Med. Services			
Case Management			
Children's Division (DFS)			
Juvenile Court			
School Counselor			
Social Worker			
Resource Specialist			
Therapy			
<b>HFCS Service</b>			
Other (please specify)			

Estimated numbers of hours per week services are needed \_\_\_\_\_ Estimated Duration \_\_\_\_\_

Are services covered by insurance or Medicaid? Yes (plan \_\_\_\_\_) No Unsure

Please describe presenting problem(s) and identified needs: \_\_\_\_\_  
\_\_\_\_\_

Please list expected outcomes: \_\_\_\_\_  
\_\_\_\_\_

Other significant notes for clinician: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis (if applicable): Axis I \_\_\_\_\_  
Axis II \_\_\_\_\_  
Axis V \_\_\_\_\_ (Present)

**HFCS Use Only:** Date Received \_\_\_\_\_ Clinician Signature \_\_\_\_\_

Qualify for DMH Children's In-Home? Yes (referred to \_\_\_\_\_) No

Current Opening? Y N Wait List? Y N

Comments \_\_\_\_\_