MorningStar
children & family services

MENTAL HEALTH SERVICES REFERRAL FORM

Date of Referral: _____ **Appointment Date and Time:** _____

Consumer Name: _____ Contact #: _____

Street Address: _____ City, State & Zip: _____

DOB: _____ Age: _____ Gender: _____ Race: _____

Medicaid #_____ Grade: _____

Current School: _____ Primary Care Physician: _____

Primary Language: _____ Living Situation: _____

Accessibility/Assistive Technology needs: _____

Guardian Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Email address: _____

Referring Person: _____ Contact #: _____

Agency: _____ Fax #: _____

Reason for Referral:

_____

_____

_____

SERVICES REQUESTED:

☐ MD Evaluation	☐ Individual Therapy	☐ Community Linkage
☐ Medication Monitoring	☐ Family Therapy	☐ Parenting/Behavior Skills
☐ RN Services	☐ Group Therapy	☐ Group Training

Method of Payment if known:

☐ Medicaid ☐WellCare ☐ Peach State ☐ Amerigroup ☐ Care Source

Private Insurance: (specify)_____

Other: (specify) _____

Is the consumer / family currently at **risk of harm** to self or others? ☐ Yes ☐ No

If Yes, explain: _____

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Call/Fax to attention of Laquanda Alston