Outpatient Mental Health Clinic
4000 Blackburn Lane, Suite 150 , Burtonsville, MD 20866 T|301-421-4241|

Referral Form

Referrals can be sent to the following address: referrals@csolutionsmh.com

Date of Referral: ______________

Client Information

Client Name: ______________________ **Age:** _____ **D.O.B:**______________

Address:

____________________ **City:** _____________________ **ZIP:** ________

SSN:

____

Ethnicity: _______________ **Gender: Male**___ **Female**___ **Other:** _________

Phone Number of Client (if applicable): _______________

☐ **School/ Education Information** (for minors/ school aged clients)

Current Grade Level :_____ **Last Completed Grade Level:** ___
Current school: _________ **Previously Attended School (if applicable):**

____

Is the client in special education/ has an IEP ? Y or N
Is the client attending a non-public school? Y or N
Does the client have a 504 Plan? Y or N

Residential Arrangement:

___**With Relative(s)** _______________________ **Lives alone** ________

Homeless/Shelter _________--**Group Home** ___ **Other:** ____________

Legal History:

Has the client ever been arrested? Y or N
If so, does the client have any previous or current Juvenile Services Involvement? Y or N
Is the client on probation? Y or N Is the client on parole? Y or N
Please enter previous and current charge(s): __

____

Parent/Guardian Information (Applicable if Under 18):

☐ Address is the same as client

Parent/Guardian Name: ____________________ **Phone:** ________________
Address: ____________________________ **City:** ___________ **State:** ______
ZIP:____________ **Email:** ___________________________
Home Phone: ______________________ **Cell Phone:** _____________________
Relationship to Client: ________________

Insurance Information

MA#: ___________________________ **Medicare#:** _________________________
Does the client have other insurance? Y or N
If yes, what is the name of the insurance carrier?: _______________________________

Referral Source

Who referred client:

____

Agency Name/ service : _____________________________
Address___________________________
Referral Phone/E-mail: _____________________________________

Reason for Referral (check all that apply):

- ☐ Behavior Challenges at ____________________
- ☐ Employment
- ☐ Sexual Abuse
- ☐ Medication Management
- ☐ Social/ Interpersonal Skills
  Mental Disorder
- ☐ Legal Issues
- ☐ Substance Abuse
- ☐ Suicidal/ Homicidal Ideation

Additional Information:

____

____

Therapy :

_______INDIVIDUAL/ FAMILY_______

Diagnosis: ______________________ **Dx code**__________

Diagnosis given by (Print name): ______________________ ____________Credentials:_________
Dx by hx or this admission _______________________________
Medication prescribed_______________________________ circle: prior to admission or new

Clinical Information

Symptoms and Behaviors (check all that apply):

☐ Depressed	☐ Physical Aggression	☐ Hyperactive
☐ Anxiety/Panic	☐ Theft	☐ Lying
☐ Hopelessness	☐ Suicidal Ideation	☐ Property Destruction
☐ Impulsivity	☐ Trauma	☐ Running Away
☐ Isolation	☐ Lack of Self-Care	☐ Mania
☐ Obsession/Compulsion	☐ Attachment Issues	☐ Irritability

If there are additional symptoms, please explain:

____

____

Has the client ever been hospitalized? Y or N

If so, what is the client's total number of hospitalizations? _____
Location and Date of most recent hospitalization & unit where services were rendered (if known): ____

Reason for admission:

____

____

Parent/Guardian Authorization Letter

I, ________________________ authorize ________________________ to be referred to Clinical Solutions, Inc for evaluation/ services as deemed appropriate and attainable.
(Parent/Guardian) (Client)

Parent Signature: ____

Client Authorization Letter (18 years or older)

I, ____ authorize to receive therapy.
(Client)

Client Signature: ____

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Disposition of Referral & Date :

Accepted _______________ Denied _______________ No response _______________
Other: ______________________ Assigned to (name/credentials)
____