DATE OF 1st CALL: **INITIALS FILLING OUT FORM:**

Referral for Community Mental Health and Substance Abuse Services

Client Information

Name:	**Date of Birth:**	**Race/Ethnicity**:
Gender: ❒ Male ❒ Female ❒ **Couple**	**School & Grade (if applicable):**	
Program: ❒ Adult ❒ Child and Adolescents		
Services Requested: ❒ Individual Counseling ❒ Psychiatric ❒ Family Counseling ❒ Group Services (PHP, PSP, etc) ❒ Nursing ❒ Case Management ❒ PSR Services ❒ Substance Abuse Counseling		
Service Location: ❒ Conyers Office ❒ Cobb County ❒ Augusta Office		
CONTACT NUMBERS:	**Message ok?** ❒ Yes ❒ No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other

Payment Information:

Type of Insurance:

❒ Medicaid: ID #_____ Phone # _____

❒ Medicare ID #_____ Phone # _____

❒ CareSource ID #_____ Phone # _____

❒ Wellcare/Peachstate: ID #_____ Phone # _____

❒ Aetna: ID #_____ Phone # _____

❒ Other : ID #_____ Phone # _____

Additional ID #_____ Additional ID # _____

If no insurance, Self-Pay Information:

_____

_____

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about AQCS?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis
	Axis I
	Axis II
	Axis III
	Axis IV
	Axis V
Prescribing Physician name & Phone	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					

Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

_____

_____

_____

Additional Comments _____

_____

Been in counseling before?:_____

Availability: _____

Counselor Preferences: _____

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