Social Care Services, LLC

Mental Health Counseling and Targeted Case Management Referral Form

Date: _____

Type of Services: _____Med Management_____Ongoing Case Management _____Counseling

Referring Person:_____ Agency_____

Address: _____ Phone:_____

Last Name:_____ First Name:_____

_____

DOB: _____ Sex____Social Security:_____Language_____

Contact Information: _____

Address: _____

Telephone:_____

Parent/Guardians/Other Name: _____

Address if different:_____

Telephone:_____

Parent/Guardian Agrees to Referral_____Yes_____No OK to call Yes____ No____

Is client currently involved in any program: Yes _____ No ___

If yes, explain: _____

Insurance Information
Plan Number _____ Group number: _____
Manage Care Plan_____ Insurance phone number from card:_____
Other Insurance _____

Reason for referral:

_____

_____

_____

Office Use
Date of Receipt _____ _____Crisis _____Urgent _____Routine
Referred to _____Appt. Scheduled _____Yes _____No
Date/Time _____ Not referred for Mental Health Services (Reason)_____

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