FREE BALTIMORE, LLC

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OUTPATIENT REFERRAL FORM

Referral Source Information

Date of Referral:		
Referring Agency Name:	***Referring Agency Address:***	
Referring Worker:	***(Title & Credentials)***	
Email Address:	***Phone:***	***Fax:***

Client Information

Consumer Name:	***DOB:*** / ***Age:***	***Race:*** / ***Gender:*** ☐ *Male* ☐*Female*		***Marital Status:*** ☐ *Single* ☐*Married* ☐*Divorced* ☐*Widowed* ☐*Separated* ☐*Other*
Social Security #:	***Legal Guardian Name:***			***Phone:***
Medicaid #:	***Emergency Contact:***			***Phone #:***
Address:	***City:***	***State:***	***Zip:***	***Veteran:*** ☐ *Yes* ☐*No*
Prim Care Physician:	***School Name:***			***Highest Level of Education:***
Prim Care Physician #:	***Employer Name:***			***Employed:*** ☐***Full time*** ☐***Part Time*** ☐***Self Employed*** ☐***Seasonal*** ☐***Unemployed***

Services Requested:

HOME BASED/COMMUNITY BASED SERVICES NEEDED? ☐YES ☐NO

☐***Mental Health Eval/Assessment***	☐***Psychiatric Rehabilitation/ PRP-ADULT/ PRP- MINOR***
☐***Individual Therapy***	☐***Psychological Testing***
☐***Group Therapy***	☐***Substance Abuse Services/ IOP or OP***
☐***Family Therapy***	☐***Psychiatric Services/ Medication Management***

History of Presenting Problems, Current Symptoms & Additional Information: *(Briefly describe individual's current problems, symptoms and needs for behavioral health services. Include any information that you feel will assist in determining eligibility and/or admission into treatment)*

History or current Substance Abuse treatment? ☐***Yes*** ☐***No***	***If Yes Where:***
Has the consumer recently been discharged from an outpatient Mental Health Facility/Hospital? ☐***Yes*** ☐***No***	***(If yes have they provided a copy of the aftercare plan?)*** ☐***Yes*** ☐***No***
Is the consumer currently on psychotropic medications? ☐***Yes*** ☐***No***	***List All Medications:***
Is the client homeless? ☐***Yes*** ☐***No***	***Arrest within the past 6 months?*** ☐***Yes*** ☐***No***

Office Use Only

Insurance Authorization Number___________________________ Number of Authorized Visits_______________________________________

Dates of Authorization From: ____________ To: _____________ Scheduled Diagnostic Interview ☐ Yes ☐ No Date: ____________________

Therapist: ____ Immunization Record Request ☐ Yes ☐ No Date: ____________________

Date Assigned/Comments: ____