HEALTH CONNECT AMERICA

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REFERRAL FORM

Please fax to: (731) 660-7512

Referring Agency Contact Information:
Name/Agency:
Relation to Client:
Phone:
Fax:
Email:
*****Have you informed the family that you are referring them for in-home services?***
Yes____ No____

If Parent/Guardian Referral:
Who referred you:

Date:___________

Please list any diagnosis and code:
____
School Person Attends:______________________________
Is the person on any medications? Yes/ no
Please list: _______________________________________

Client: ______________________________________ **Date of Birth:** ____/_____/______

Social Security Number: ____________________________ **Gender: Male** _____ **Female** _____

Race: African-American ___ **Asian** ___ **Caucasian** ____ **Latino**___ **Native-American** ___ **Other** ___

Legal Status: Citizen:____ **Alien:**____

Parent / Guardian: ______________________ **Relationship:** __________________________

Client Address: _________________________________**City**___________ **Zip Code**________

Home Phone Number: ____________ **Work Phone:** ______________**Cell Phone:** ______________

E-Mail: _____________________

Please answer the following questions about the person you are referring:
What behaviors has the person been exhibiting? ***(drop in grades, decreased school performance/attendance, physical/sexual/emotional aggression, missing curfew, sexual inappropriateness, etc.)***____
____
____
____

Has the person experienced recent trauma that might have led to the above behaviors? (***death of a loved one, divorce/break-up, sexual molestation, etc.)*** ____
____
____

What services have been tried in the past? ____
____

Other relevant information about this referral: ____
____
____

OFFICE USE ONLY:	
CONTACT LOG	
1.	TENNCARE VERIFIED_____
2.	ENTERED IN ROLLUP_____
3.	ASSESSMENT SCHEDULED______
4.	ASSESSMENT COMPLETE _______
5.	ASSESSMENT STAFF ___________

Revised 06/10