

DATE OF 1st CALL:

Person Completing Form:

Nurture of Alabama, L.L.C.
Referral Form for Mental Health Services

Client Information

Name: Date of Birth:		Race/Ethnicity:
Partner Name:	Date of Birth:	Race/Ethnicity:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Couple	School & Grade:	
Services Requested: <input type="checkbox"/> Office-Based Outpatient		
Service Location: <input type="checkbox"/> Downtown Office <input type="checkbox"/> Home <input type="checkbox"/> School (if, applicable)		
CONTACT NUMBERS:	PARTNER CONTACT NUMBERS:	Message ok? <input type="checkbox"/> Yes <input type="checkbox"/> No
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian: Address:
Contact Numbers: Type of setting: <input type="checkbox"/> Home <input type="checkbox"/> Group Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Other

Payment Information:

Type of Insurance <input type="checkbox"/> Medicaid (DHR) <input type="checkbox"/> BCBS <input type="checkbox"/> Other	GROUP#
Effective Date:	List Insurance:
Insurance ID#	
Secondary Insurance ID#	Benefits Phone #
We offer services on a sliding scale basis, please contact us for more 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 Nurture of Alabama, LLC?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis
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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: