



Agency/Program Referral Form

Date of Referral:			
Please email this referral to:			
<input type="checkbox"/> Outpatient Behavioral Health: bhreferrals@caringsync.org		<input type="checkbox"/> Residential Treatment: hhtreatment@caringsync.org	
Referral Source:			
Agency:			
Staff's Name and Title:			
Contact #:		Email:	
Client Information:			
Client Name:			
DOB:		Social Security #:	
Address:			
Phone:			
City, State, and Zip:			
Gender:			
Hearing Status:	<input type="checkbox"/> Deaf <input type="checkbox"/> Hearing <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deafblind		
Vision Status:	<input type="checkbox"/> Low Vision <input type="checkbox"/> Total Blindness <input type="checkbox"/> Legally Blind		
Preferred Method of Communication:	<input type="checkbox"/> Visual <input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Written <input type="checkbox"/> Tactile System <input type="checkbox"/> Other:		
Primary Language:	<input type="checkbox"/> American Sign Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Technologies for Communication:	<input type="checkbox"/> Screen Braille Communicator <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> Closed Captioning <input type="checkbox"/> Assistive Listening Devices <input type="checkbox"/> CART/ Live Captioning <input type="checkbox"/> Captioned Phone <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Videophone or Video relay Service <input type="checkbox"/> Other:		
Housing Status:	<input type="checkbox"/> Outside/Street <input type="checkbox"/> Family/Friends <input type="checkbox"/> Transitional <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Hospital <input type="checkbox"/> Private/Independent <input type="checkbox"/> Shelter/Assessment Center <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Other:		
Type of Insurance:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> PeachState <input type="checkbox"/> CareSource <input type="checkbox"/> VA <input type="checkbox"/> Uninsured <input type="checkbox"/> Other:		
Insurance Number:	<input type="checkbox"/> Not Applicable		
Guardian/ Emergency Contact Information:			
Name:			
Relationship to client:		Phone:	
Address:			
City:		State:	Zip Code:
Please check all that apply:			
<input type="checkbox"/> Individual has discharged from psychiatric facility/crisis stabilization unit within last 72 hours.			
<input type="checkbox"/> Individual has successfully completed residential treatment in the last 90 days.			
<input type="checkbox"/> Individual has completed a psychiatric evaluation within the past 12 months.			
<input type="checkbox"/> Individual has been identified as having a mental health diagnosis.			
Disposition (for CaringWorks use only)			
Screening Decision:	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected <input type="checkbox"/> Pending <input type="checkbox"/> Referred to another program: _____		
Reason for Above Action:			
Comments: (Optional)			
Staff Signature:			
Date:			