|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referer INFORMATION | | | | | | | | | | |
| Referring Agency/Clinician: | | | | | Today’s date: | | | | | |
| Street address: | | | | | Office Phone: | | Office Fax: | | | |
|  | | | | | ( ) | | ( ) | | | |
| City, State & ZIP Code: | | | | | E-mail Address: | | | | | |
| CLIENT INFORMATION | | | | | | | | | | |
| Client’s Full Name: | |  |  | | ❑ Mr.  ❑ Mrs. | ❑ Miss  ❑ Ms. | Marital status (circle one) | | | |
|  | | | | | Sin / Mar / Div / Sep / Wid | | | |
| Street address: | | | | | Birth date: | | Age: | | Sex: | |
|  | | | | | / / | |  | | ❑ M | ❑ F |
| City, State & ZIP Code: | | | | | Home Phone: | | Alternate phone: | | | |
|  | | | | | ( ) | | ( ) | | | |
| Is client aware of this referral? ❑ Yes ❑ No | | | | Is it okay to leave a message? ❑ Yes ❑ No | | | | | | |
| Is client covered by insurance? ❑ Yes ❑ No | | | | | | | | | | |
| Please indicate primary insurance: | | ❑ Medicaid/MHNet | | ❑ Medicare | | ❑ MC+ | | ❑ Aetna | | |
| ❑ BCBS | ❑ TriCare | ❑ Healthcare USA | | ❑ UHC | | ❑\_\_\_\_\_\_\_\_\_\_\_ | | ❑ \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| referraL INFORMATION | | | | | | | | | | |
| Reason for Referral: ❑ Diagnostic Evaluation ❑ Assessment ❑ Individual Therapy ❑ Group Therapy  ❑ Other Please elaborate | | | | | | | | | | |
| Current Diagnosis: ❑ Rule Out? ❑ PTSD ❑ Acute Stress Reaction ❑ Acute Stress Disorder  Other current DSM/ICD Diagnoses: | | | | | | | | | | |
| Presenting issue(s): ❑ Re-experiencing ❑Avoidance/Numbing ❑ Increased Arousal ❑ Depression  Please elaborate and include details pertaining to other presenting issue(s) and functional impairments. | | | | | | | | | | |
| referraL INFORMATION continued | | | | | | | | | | |
| History: Please include details pertaining to experienced traumatic event if known. Record other relevant biological, physiological, social, substance abuse, or physical health problems. | | | | | | | | | | |
| Risks and co-morbidities: Note any suicidal ideation or intent, plans, means and or risks to others. Note protective factors preventing risks, including family support and any agreed safety plans. | | | | | | | | | | |
| Current Medications:  Other Services: | | | | | | | | | | |
| Other Relevant Information: | | | | | | | | | | |
| Please direct referrals to Jennifer Webster via fax (816) 404-5739 or email [jennifer.webster@tmcmed.org](mailto:jennifer.webster@tmcmed.org)  Please include a signed release of information form with your completed referral form.  For questions or additional information about our services, please call (816) 404-5878. | | | | | | | | | | |