Referral Information

The Program requires a complete admission application to assure that the consumer needs and best interests of each applicant are met. The following information is needed to begin the application process.

Date of referral _____ Referring Counselor _____ Referring Agency _____

Referring Counselor Phone & Email _____ _____

Client Name_____ DOB_____ SS# _____

Is client their own legal guardian? ☐ Yes ☐ No If no, please give name of legal guardian_____

Client/Legal Guardian Address _____

City _____ State _____ Zip Code _____ Phone _____

Primary insurance _____ Secondary insurance _____

Criminal Record ☐ Yes ☐ No (If so please attach a brief explanation)_____

Current Symptoms/Behavioral Observations

__Anxiety	__Gets angry easily	__Substance use	__School work problems
__Attention problems	__ Impulsivity	__ Suicidal thoughts	__ Relationship concerns
__ High risk activities	__ Mood swings	__ Tantrums/Rages	__ Hopelessness

Services Requested

__Outpatient therapy	__Intensive in home	__Diagnostic Assessment	__Supportive employment
__Community support team	__Substance abuse services	__Transitional living community support	__Residential level III

Known diagnosis: _____

_____

Medical problems: _____

_____

Medications: _____

A determination as to the most appropriate services for each consumer will be made based on this information; therefore, it is important to know as much as possible about each applicant. We ask that you provide the above information in it's entirety before we start working with the client, so that we can make an accurate assessment of services needed.

Please forward all information to:
Primary Care Solutions of Ohio, Inc.
1336 E. Main St. Unit B Columbus, OH 43205 Phone: 614-914-8781 Fax: 614-914-8941