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	__Community Psychiatric Support Team Services	__Diagnostic Assessment	__Psychiatric Assessment
__Crisis Response	__Peer Support Services	__Transitional living community support	__Residential

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 its 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 Ohio

2940 Noble Rd. Suite 101 Cleveland Heights, OH 44121 Phone: 567.312.8700 Fax: 567.312.8793