



## 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**

500 Madison Ave. Suite 300 Toledo, OH 43604 Phone: 567.312.8700 Fax: 567.312.8793