WORKING CONCEPTS INC.

110 Habersham Drive Ste. 325 Fayetteville, GA 30214
770-371-5171 X 325
referrals@workingconceptsinc.org

Adolescent Referral Information (Ages 7 to 17)

Referral Form

(Please Print)

NAME OR AGENCY OF REFERRAL

Name: ____

Position: ____

Agency: ______________________________ Email____________________________________

Date: ___________________________ Phone: (_______) ___________________________

CLIENT INFORMATION:

Name: ____

Birth date: ____

SSN ____________________________ Ethnicity: _______________ Gender __________________

Street Address: ____City: _______________

Zip Code: _____________ County: ____

School: ____ Grade Level: __________________

Current Placement:
(residence)____

Parent/Guardian Name _______ Relationship____

Home Phone _________________ Cell Phone ____

INSURANCE

❑ PeachState/ Medicaid ❑ CareSource

SERVICES NEEDED:(CHECK ALL THAT APPLY)

❑ In-home Intensive Individual and/or Family Intervention (IFI)

❑ Children Intervention School Service

❑ Mentoring

❑ Behavior Modification

❑ Anger Management

❑ Psychological Evaluation

❑ Targeted Case Management

YOU ARE REQUESTING MENTAL/BEHAVIORAL HEALTH SERVICES? (DESCRIBE THE PROBLEM(S)

____

____

____ ____________

____

____

ADDITIONAL INFORMATION NEEDED FOR INTAKE (REQUIRED TO PROCESS REFERRAL):

❑ Number in Family: ____________________ Family Income (approximately): ____________________

❑ Child currently on medication? Yes or No (circle one). If so, name of med(s): _________________________________

❑ Child on Probation? Yes or No (circle one) If so, number of arrest: _____________________

❑ History of Substance Abuse? Yes or No (circle one). If so, name of substance(s): _______________________

DO NOT WRITE BELOW

FOR OFFICE USE					
CLIENT #:	REFERRAL RECEIVED DATE	BY	REFERRAL ASSIGNMENT DATE	TO	TCM/THERAPIST/PSR

PLEASE EMAIL THE COMPLETED REFERRAL FORM TO: referrals@workingconceptsinc.org

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Adult Referral Information (Ages 18 and up)

Referral Form

(Please Print)

Name or Agency of Referral

Name:	Position or Title:
Agency:	Email:
Date of Referral:	Phone:

CLIENT INFORMATION

Client Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Divorce / Sep / Widow
Spouse/Partner Home Phone or Cell Phone:					

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	SSN#:	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

Chose clinic because/Referred to clinic by:

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

Is this client covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance	❑ CareSource	❑ PeachState/ Medicaid	❑ Ambetter/Exchange		
Name:	SSN #:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to client: ❑ Self ❑ Spouse ❑ Child ❑ Other

Services Needed

❑ Targeted Case Management ❑ Crisis Intervention ❑ Anger Management

❑ Intensive Family Intervention (IFI) ❑ Wrap-Around Services ❑ Psychological Evaluation

❑Skill Building-Prevocational Services ❑Skill Building - Vocational Services ❑ Other

REASON (S) you are requesting Behavioral Health/Career Services? (Description)

Is the client (check all that apply)

❑ Age 18 years or older and not enrolled in a K-12 educational program?
❑ At risk of out of home placement (hospital, MH residential, SA residential, etc.)?
❑ Been identified to have a mental health, DSM-IV, diagnosis?
❑ Committed acts of physical or verbal aggression against others?

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