AOLAT TREATMENT PLACE, INC
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MENTAL HEALTH
PROGRAM REFERRAL FORM

REFERRAL SOURCE INFORMATION

Date of Referral: _____

Referring Agency/Address: _____

Phone: _____ Fax Number: _____

Name of Referrer: _____ Email Address: _____

CONSMER INFORMATION

Name: _____ Gender: _____ Marital Status: _____

DOB: _____ RACE: _____ Phone Number: _____

SSN: _____ Medical Assistance #: _____

Address: _____ Zip Code: _____

Email: _____

If consumer is a child:

Legal Guardian Name: _____ Relationship to Consumer: _____

Foster Parent: No Yes (If so please provide a copy of the court order)

School: _____ Grade: _____ IEP/504: Yes No

Services Requested:

- ❑ Mental Health Evaluation/ Assessment
- ❑ Individual Therapy/Family Therapy/Group Therapy
- ❑ Case Management
- ❑ Medication Management
- ❑ Psychiatric Rehabilitation Services (PRP)
- ❑ Diagnostic Testing

Presenting Problems: _____

_____

Current Medications: (Please include name and dosage)

Has the consumer recently been discharged from therapy services? No Yes

Has the consumer been arrested in the past six months? No Yes

Is the consumer a Veteran? No Yes

FOR AGENCY STAFF USE ONLY

Insurance Authorization #: _____ # of Authorized visits: _____

Dates of Authorization: _____ to _____ Date Assigned: _____