AOLAT TREATMENT PLACE, INC

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PSYCHIATRIC REHABILITATION PROGRAM
PROGRAM REFERRAL FORM

REFERRAL SOURCE INFORMATION

Date of Referral: _____ Referring Agency _____

Title and Credentials: _____ Phone_____

Fax Number: _____ Email Address: _____

CLIENT INFORMATION

Consumer Name: _____ Gender: _____ Marital Status: _____

SSN: _____ DOB: _____ AGE: _____ RACE: _____

Medical Assistance #: _____ Legal Guardian: _____

Full Address: _____

Phone: _____ Alternate Phone: _____

Primary Care Physician: _____ Phone Number: _____

Employer/School: _____ Grade: _____

Address: _____ Phone:_____

Rehabilitation Services Needed:

❑ Coping Skills	❑ Assertiveness/Self-esteem	❑ Adult Vocational/Educational Skills
❑ Social Skills/Peer Interaction	❑ Behavior Interventions	❑ School Performance
❑ Other:	❑ Other:	❑ Other

Current Treatment: Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates.

1. _____

2. _____

Diagnosis: please indicate current DSM V diagnoses.

ICD 10 Code: _____ DSM V Code: _____

ICD 10 Code: _____ DSM V Code: _____

Diagnosis given by: _____ Date: _____

Medications (Please provide name and dosage amount)

Date: _____ **Signature:** _____

Please return this form to refer@aolatplace.com

Please forward the most recent assessment and/or treatment plan when sending this referral.

Date Received: Approve/Denied	Coordinator Assigned Assignment Date:	Authorization Dates: