CLIENT DEMOGRAPHIC & REFERRAL RECORD

Case Directors: George A. Pate or Kayley B. Pate

Demographic Information

Guardian full name: _____

Email: _____ Phone: _____

Client Details

Client/Case number: _____ SSN: _____

First name: _____ Middle: _____ Last: _____

Ethnicity: _____ Gender: _____ Date of birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: Home Address:

Payor Information

Primary Payer (insurance company): _____

Insurance ID: _____ Insurance Copayment: $ _____

Primary Insured: _____ Relationship to Patient: _____

First name: _____ Middle: _____ Last: _____

Ethnicity: _____ Gender: _____ Date of birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Secondary Payer (insurance company): _____

Insurance ID: _____ Insurance Copayment: $ _____

Primary Insured: _____ Relationship to Patient: _____

First name: _____ Middle: _____ Last: _____

Ethnicity: _____ Gender: _____ Date of birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Referral Details

Referring provider name: _____

MD/NP License #: _____ NPI #: _____ Medicaid #: _____

Phone: _____ FAX: _____

Email: _____ Referral Expiration Date: _____

Current Client Medical &/or Mental Health Diagnoses

Diagnosis: _____ Date: _____

Diagnostician: _____

(Person who made the diagnosis & his or her credentials)

Diagnosis: _____ Date: _____

Diagnostician: _____

(Person who made the diagnosis & his or her credentials)

Diagnosis: _____ Date: _____

Diagnostician: _____

(Person who made the diagnosis & his or her credentials)

Diagnosis: _____ Date: _____

Diagnostician: _____

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Diagnosis: _____ Date: _____

Diagnostician: _____

(Person who made the diagnosis & his or her credentials)

Behaviors & Skill Deficits of Concern *(reason/s for referral)*

(Print, in detail, the top 5 client behavior/s or skill deficit/s of concern to the caregiver/ s, teacher/s, or physician that have occurred in the last 14 days; how long the behavior lasted, was there personal or property damage, etc.)

1.) _____

_____

_____

2.)

3.)

4.)

5.)

Please provide a list of all prescriptions and any other treatment services you or your dependent/s are currently receiving or are planning to receive in the next 6 months.

Also provide all mental, medical, social and educational program and treatment records for the past six months