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RAVENS NEST FOUNDATION, INC.

**INTAKE/REFERRAL FORM**

**Phone: (770) 819-6825**

**Fax: (770) 819-6826**

**REFERRAL DATE**: **Click here to enter a date.**

**CLIENT DEMOMGRAPHIC**

Client Name: **Click here to enter text.** ID #: **Click here to enter text.**
Address: **Click here to enter text.**

City: **Click here to enter text.** State: **Click here to enter text.** Zip: **Click here to enter text.**

DOB: **Click here to enter text.** SS #: **Click here to enter text.** Telephone #: **Click here to enter text.**
[ ] Male [ ] Female [ ] Telephone [ ] Walk-in [ ] Fax [ ] Email

Insurance Carrier: **Click here to enter text.** Insurance Subscriber: **Click here to enter text.**

Guardian/Parent: **Click here to enter text.** Telephone #: **Click here to enter text.**

Contact Person: **Click here to enter text.** Relationship: **Click here to enter text.**
Telephone: **Click here to enter text.** E-mail Address: **Click here to enter text.**

**REFERRAL SOURCE**

Referral Source: **Click here to enter text.** Telephone #: **Click here to enter text.**

Referral email: **Click here to enter text.** Referral Fax#: **Click here to enter text.**

**PRESENTING PROBLEM**

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**CLINICAL INFORMATION**

Have you ever received mental health or substance abuse services before? [ ] Yes [ ] No
If “Yes” When? Where? **Click here to enter text.**

Are you on medication? [ ] Yes [ ]  No If “Yes” List Medication

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| **Med Name** | **Dose/Freq** | **Effective? Explain** | **Compliance** | **Physician Name** | **Telephone #** |
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What type of services are you requesting? **Click here to enter text.**
Has the consumer had a psychological or psychiatric evaluation in the past year? If so please list provider name and location: **Click here to enter text.**

Is the client involved with court? [ ] **Yes** [ ] **No** (If applicable, please list court date, PO, etc.)

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**SCHOOL INFORMATION**

Current School Name & Location ***(If Applicable)***: **Click here to enter text.**

**Is Child Receiving SST or Special Education: Yes** [ ]  **or No** [ ]

**If yes, please indicate which programs:** [ ]  **SST or** [ ]  **Special Education**

**TRANSPORTATION INFORMATION**

How will the client be transported to the session?

**How will the client be transported to sessions?** [ ] **Drive self** [ ] **Family/friend** [ ] **In-Home** [ ] **Police**