Referral Date: ___/___/___

MENTAL HEALTH SERVICES REFERRAL

1008 Bullard Ct., Raleigh NC 27615
Office: (919) 833.3312 Fax: (919) 833.3512

SERVICES REQUESTED

please check all that apply

☐ MENTAL HEALTH ASSESSMENT ☐ OUTPATIENT THERAPY ☐ MULTI SYSTEMIC THERAPY

☐ PSB ASSESSMENT ☐ PSB TREATMENT ☐ UNSURE

I. CLIENT INFORMATION

CLIENT LEGAL NAME:	
PREFERRED NAME: (if different from legal name)	
ADDRESS:	
DATE OF BIRTH:	AGE:
RACE/ETHNICITY:	ASSIGNED SEX AT BIRTH ☐ FEMALE ☐ MALE

WHERE IS CLIENT CURRENTLY RESIDING:

☐ HOME ☐ OTHER EXTENDED FAMILY ☐ FOSTER HOME OR FOSTER PLACEMENT ☐ DETENTION

☐ TREATMENT FACILITY ☐ HOSPITAL OR PRTF ☐ HOMELESS / SHELTER ☐ OTHER ____________________

INSURANCE PROVIDER:

☐ NONE ☐ MEDICAID (please specify MCO) ____________________________

☐ SELF PAY ☐ PRIVATE INSURANCE (please specify) ________________________ ☐ STATE FUNDS

II. LEGAL CAREGIVER INFORMATION

LEGAL CAREGIVER NAME:	RELATIONSHIP TO YOUTH:
ADDRESS:	EMAIL:
PHONE: (H)	(C)
HAS THE YOUTH'S PARENT/LEGAL GUARDIAN BEEN INFORMED OF THIS REFERRAL? ☐ YES ☐ NO	PRIMARY LANGUAGE SPOKEN AT HOME (check all that apply) ☐ ENGLISH ☐ SPANISH ☐ OTHER

III. REFERRAL SOURCE INFORMATION

NAME OF INDIVIDUAL COMPLETING REFERRAL:	NAME OF REFERRAL SOURCE AGENCY OR ENTITY: (if applicable)
REFERRAL SOURCE PHONE NUMBER:	REFERRAL SOURCE EMAIL ADDRESS:

REFERRAL SOURCE RELATIONSHIP TO CLIENT:

☐ SELF- REFERRED ☐ LEGAL CAREGIVER ☐ DEPT. OF SOCIAL SERVICES ☐ SCHOOL

☐ SRO / LAW ENFORCEMENT ☐ DEPT. OF JUVENILE JUSTICE / COURT COUNSELOR

☐ INTERNAL AGENCY REFERRAL ☐ MCO / INSURANCE PROVIDER ☐ MENTAL HEALTH PROVIDER

☐ OTHER COMMUNITY AGENCY ☐ OTHER

IV. HISTORY OF PRESENTING PROBLEMS

please check all that apply

☐ ACADEMIC FAILURE	☐ NEGATIVE PEER ASSOCIATIONS	☐ STEALING
☐ ASSAULT/AGGRESSIVE BEHAVIOR	☐ PHYSICAL/MENTAL ABUSE	☐ SUBSTANCE USE
☐ DELINQUENT BEHAVIOR	☐ POOR SOCIAL SKILLS	☐ SUICIDE ATTEMPTS
☐ EXCESSIVE DEPENDENCE ON PARENTS	☐ PROSTITUTION	☐ SUICIDE THREAT(S)
☐ FEELINGS OF ANXIETY	☐ RUNAWAYS	☐ TEMPER TANTRUMS
☐ FIRE SETTING	☐ SCHOOL BEHAVIOR PROBLEMS	☐ TRAUMA
☐ GANG ASSOCIATE	☐ SELF-MUTILATION	☐ TRUANCY
☐ GANG INVOLVEMENT	☐ SEXUAL ABUSE	☐ WITHDRAWN, DEPRESSION
	☐ SEXUAL OFFENSE	☐ OTHER ____________________

BRIEFLY DESCRIBE REASON FOR REFERRAL AT THIS TIME:

IS THE YOUTH COURT INVOLVED? ☐ YES ☐ NO	COURT COUNSELOR/PROBATION OFFICER? ☐ YES ☐ NO
IS THE YOUTH ENROLLED IN SCHOOL? ☐ YES ☐ NO	IF YES: ______________________________/___________ SCHOOL NAME GRADE

OTHER PROVIDERS, SERVICES, OR AGENCIES INVOLVED WITH CLIENT:

REFERRAL RECEIVED: _____/ _____/ _____

STAFF RECEIVING REFERRAL: ____________________________

Haven House Services, 1008 Bullard Ct., Raleigh, NC 27615
Phone: (919) 833.3312 Fax: (919) 833.3512