TRANSITION CENTER

NEW CLIENT REFERRAL FORM

Date of Referral: __________________ Referral Source: _________________________________

Referral Source Phone: _______________________ Fax: ________________________

Referral Source Email: ____

CLIENT INFORMATION

Client Name: ____ ☐ Male ☐ Female

Client Legal Guardian (if minor): ____

Client Address: ____

City: _______________________ State: _____________ Zip: ________________

Social Security #: ______________________ Date of Birth: __________________

Home Phone: _________________________ Cell Phone: _________________________________

Summary of Prior record if applicable: (attach a sheet if needed)

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Have you ever been charged with or convicted of arson or a sex crime? YES ___ NO ___

History of substance abuse? (specify & explain)

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Any history of mental health issues, diagnoses or medication? (Specify & explain)

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10. How is your general health?

Good _____ Fair _____ Poor _____

11. Briefly describe any health or medical issues:

____

12. Is the client taking any medications? If so, list:

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INSURANCE INFORMATION

* a copy of the front and back of the insurance card is required*

Primary Insurance: ____

Customer Service Number: ____

Identification Number: ____

Name of Policyholder: ____

Relationship to Client: ____________________ DOB of policyholder: _________________

SS# of policyholder: ______________________ Employer: ___________________________