



DJJ Referral Form

Date of Referral: _____

(Please Print)

Name & Title of Person making referral: _____

Agency: _____ County: _____ Court Mandated? Yes No

Phone # of person making referral: _____ Fax number: _____

Email: _____

How did you hear about us? _____

Client Information:

Client Name: _____ Guardian Name: _____

Medicaid / TriCare / Aetna / Amerigroup Policy#: _____

Date of Birth: _____ Age: _____ SS# _____ Grade Level _____

Gender: (Please Check) Male Female Race: _____

Placement Address: _____ City _____

State _____ Zip _____

Home Phone#: _____ Cell #: _____ Work #: _____

Services Background:

1. Has the client had other services (e.g. CORE/IFI, Hospitalization, Individual and /or Family Counseling)?
 Yes No Not Sure
2. Does the client have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis?
 Yes No Not Sure
3. Has a Psychological/Psychiatric Evaluation been completed in the past? Yes No **If yes, please attach**

Service (s) Requested

- Anger Assessment Substance Abuse Assessment Behavioral Assessment Parenting Assessment
 Home Evaluation Educational Assessment Individual /Crisis Counseling Training/Supervision
 Other _____

Presenting Problem:

(List problem behaviors; include any medications for emotional and / or behavior problems)

For Office Use Only:

Receipt Date: _____ **Insurance Active** Yes No **Medicaid Plan:** _____

Assigned to: _____ **Date Assigned:** _____

Assessment Completion Date: _____ **Consumer Approved?** Yes No

If not approved, why? _____

If approved: Date _____ **Fee** _____ **Payor Source** _____