1400 NW 54th St., Suite 102, Miami FL 33142
Tel: (305) 693-3508, Fax: (305) 693-3510

# Referral Form

## Prospective Member Information

Name: ______________________________ Date of Birth: ____________________

Address : ____________________________________ SSN: ______/______/________

City: ____________________ State: ______ Zip: __________ Tel: (______) ______________

| Diagnosis | Medications |
|---|---|
| | |
| | |
| | |
| | |

Medicaid Recipient? ❑ NO ❑ YES, if yes: HMO: ________________________________
(Name of HMO)

Reason for Referral/Goals: ______________________________________________

| Risk Assessment | | |
|---|---|---|
| Behavior | History | Current Activity Level |
| Violence | ❑ NO ❑ YES | ❑ None ❑ Minimal ❑ Moderate ❑ High |
| Suicide Attempt(s) | ❑ NO ❑ YES | ❑ None ❑ Minimal ❑ Moderate ❑ High |
| Alcohol/Drug Abuse | ❑ NO ❑ YES | ❑ None ❑ Minimal ❑ Moderate ❑ High |
| Sexual Exploitation | ❑ NO ❑ YES | ❑ None ❑ Minimal ❑ Moderate ❑ High |

## Psychiatrist/Licensed Clinician Information — Please Fill Out Completely

Name: ____________________________________ Date: __________________

Address: __________________________________ Tel: (______) ______________

City: ______________________ State: __________ Zip: ____________

License #: ____________________ Occupation______________________

Signature: ______________________________________