**Region IV Mental Health Services Referral for Services**

**Referral Source:**

Person Submitting Referral: Date Submitted to Region IV: \_\_\_\_\_\_\_\_\_

Email address:

School Name: Phone:

City, State: Fax:

**Individual information**

Name: Social Security Number:

Date of Birth: Race Gender

Grade: Phone: Phone:

Address: City, State, Zip:

**Parent or Legal Guardian Information:**

Name: Relationship:

Address: Phone:

City, State, Zip: Phone:

Household size: Household Annual Income:

**Reason for Referral**

|  |  |  |
| --- | --- | --- |
| ( ) Discharge from acute care | ( ) Eating Disorder | ( ) Depression |
| ( ) Behavior Problems | ( ) Substance Abuse | ( ) Anxiety |
| ( ) Family Issues | ( ) Psych eval | ( ) Physical Abuse |
| ( ) Problems at school | ( ) Sexual Abuse | ( ) Psychosis |
| ( ) Suicidal Thoughts | ( ) Homicidal Thoughts | ( ) ADHD |
| Additional Comments: | | |

**To be completed by Region IV Staff**

**Payment Information:**

Please attach copy of insurance card or enter the following information:

Policy Holder Name: Relation:

Address: City, State, Zip:

Primary Insurance Co: Phone Number:

Policy Holder SSN: Policy Holder DOB:

Insurance ID No:

Secondary Insurance Co: Phone Number:

Policy Holder SSN: Policy Holder DOB:

Insurance ID No;

NOTE: Insurance Verifier must have three business days prior to scheduled intake to enter

information in Essentia and verify insurance.

Date/Time of intake appointment and with whom: