Pike County Behavioral Health Services

Referral Form

CLIENT INFORMATION

Name _____ DOB ___/___/___ Gender ☐ M ☐ F

Address _____ Phone # _____

City, State, Zip _____

Parent/Guardian Name _____ Phone # _____

REFERRAL SOURCE

Referral Source ☐ Self ☐ Parent/Guardian ☐ Hospital _____ ☐ PCP _____

☐ DFS ☐ Head Start ☐ Other _____

Contact Person _____ Email _____

Phone # _____ Fax # _____

SYMPTOMS AND/OR BEHAVIORS

- ☐ Anxiety, irritability, or restlessness
- ☐ Depression
- ☐ Emotional Outbursts
- ☐ Self abuse or mutilation
- ☐ Exacerbation of health problems
- ☐ Social isolation or withdrawal
- ☐ Non compliant with medical care
- ☐ Sleep problems or disorders
- ☐ Homicidal thoughts
- ☐ Argumentative or uncooperative
- ☐ Poor adjustment to a medical condition
- ☐ Decline in functioning
- ☐ Danger to self or others
- ☐ Aggressive or disruptive behavior
- ☐ Inappropriate sexual behavior
- ☐ Poor appetite or significant weight concerns
- ☐ Hallucinations
- ☐ Phobias
- ☐ Extreme mood changes
- ☐ Schizophrenia
- ☐ Suicidal thoughts
- ☐ Impulsive
- ☐ Substance use/abuse
- ☐ Personality disorder
- ☐ Other:

ADDITIONAL INFORMATION

Are there any safety concerns for this client? ☐ Yes ☐ No

If Yes, please explain

Notes

Signature _____ Date _____