



UNIVERSAL REFERRAL FORM

PRP · Therapy · Med Management · Substance Use · IOP
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Joint Commission Accredited | BHA Licensed

SERVICES REQUESTED (check all that apply)

☐ PRP ☐ Therapy ☐ Med Management ☐ Substance Use ☐ IOP

SECTION 1 — CLIENT INFORMATION

Required for all services

Date of Referral:

Medical Assistance #:

SSN:

Gender: ☐ M ☐ F ☐ Other Age:

Race / Ethnicity:

School:

Grade / Highest Grade Completed:

Address:

City: State:

Parent / Legal Guardian:

Relationship to Client:

Guardian Phone:

Guardian Email:

Client Name:

Date of Birth:

Primary Language:

Home Phone:

Cell Phone:

Work Phone:

ZIP:

Referring Provider Name:

License Type & Number:

Date of Last Session:

INSURANCE / PAYMENT INFORMATION

Insurance: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Self-Pay

☐ Other:

Plan/MCO:

Member ID:

SECTION 2 — CLINICAL INFORMATION

Required for all services

DSM-5 Code(s) — include Rule-Out or Provisional:

Clinical Summary / Justification (REQUIRED):

Documentation attached to verify diagnosis? ☐ Yes ☐ No

Client currently receiving therapy? ☐ Yes ☐ No

Client in need of therapy? ☐ Yes ☐ No

SECTION 3 — REASON FOR REFERRAL

Check all that apply

- | | | |
|--|---|--|
| ☐ Behavior/Conduct Challenges | ☐ Emotional/Mental Illness | ☐ Educational Challenges |
| ☐ Employment Instability | ☐ Financial Instability | ☐ Legal/Incarceration |
| ☐ Medication Management | ☐ Physical/Emotional Abuse | ☐ Relational Conflicts |
| ☐ Sexual Abuse | ☐ Suicidal/Homicidal | ☐ Substance Abuse |
| ☐ Social/Interpersonal Challenges | ☐ Caregiver Burden / Burnout | ☐ Risk of Out-of-Home Placement |



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SUBSTANCE USE INFORMATION

Primary substance(s):	Last use/date:
Frequency/amount:	Route of use:
History of overdose? ☐ Yes ☐ No	Withdrawal risk/symptoms? ☐ Yes ☐ No
Prior detox/residential/IOP? ☐ Yes ☐ No	Medication for SUD? ☐ Yes ☐ No
Additional substance-use history:	

SAFETY & RISK SCREENING

Current suicidal thoughts? ☐ Yes ☐ No ☐ Unknown	Current homicidal thoughts? ☐ Yes ☐ No ☐ Unknown
Recent self-harm? ☐ Yes ☐ No ☐ Unknown	Psychosis/severe instability? ☐ Yes ☐ No ☐ Unknown
Risk of severe withdrawal? ☐ Yes ☐ No ☐ Unknown	Naloxone available/needed? ☐ Yes ☐ No ☐ Unknown

If there is an immediate medical or psychiatric emergency, use emergency/crisis services rather than routine referral.

PSYCHOSOCIAL / LEGAL / SUPPORT NEEDS

Housing: ☐ Stable ☐ Unstable ☐ Homeless	Transportation barrier? ☐ Yes ☐ No
Legal involvement? ☐ Yes ☐ No	Probation/Parole Officer:
Employment/School:	Family/support system:
Other barriers or needs (food, childcare, benefits, domestic safety, etc.):	

SECTION 4 — SYMPTOMS & RISK BEHAVIORS

Check all that apply

- | | | | |
|---|---|--|---|
| ☐ Anxiety/Panic | ☐ Attachment Problems | ☐ Depressed | ☐ Fire Setting |
| ☐ Homicidal Ideations | ☐ Hopeless/Helpless | ☐ Hyperactive | ☐ Impulsive |
| ☐ Irritable | ☐ Isolative | ☐ Lying/Manipulative | ☐ Manic Mood |
| ☐ Obsession/Compulsion | ☐ Oppositional Defiant | ☐ Physical Aggression | ☐ Property Destruction |

- | | | | |
|---|--|--|--|
| ☐ Running Away | ☐ Self-Care Deficit | ☐ Self-Injurious Behavior | ☐ Separation Problems |
| ☐ Sexually Inappropriate | ☐ Social Withdrawal | ☐ Stealing | ☐ Suicidal Ideations |
| ☐ Trauma-related | ☐ Truancy | ☐ Verbal Aggression | |

SECTION 5 — SERVICES NEEDED

Check all that apply

- | | | |
|---|--|---|
| ☐ Adaptive Equipment & Resources | ☐ Educational Support | ☐ Employment Support |
| ☐ Independent Living Skills | ☐ Health Promotion & Training | ☐ Housing Support |
| ☐ Self Care Skills | ☐ Social Skills & Community Support | |

SECTION 6 — SIGNATURES & CONSENT

Required for all services

By signing below, the referring licensed mental health professional acknowledges that the client /guardian has provided proper signed or verbal consent to disclose and receive information regarding initiation of the requested service(s).

Print Name & Credentials:

Signature:

License Type & Number:

Date:

Phone:

Email:

FOR SHARE WELLNESS CENTER INTAKE USE ONLY

Received by:

Date:

Assigned to:

Auth Req: