Serenity
Psychological Services & Consulting

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# Referral Form for Mental Health Services

## Client Information

| | | |
|---|---|---|
| Name: | Date of Birth: | Race/Ethnicity: |
| Gender: ❒ Male ❒ Female | | |
| Services Requested: ❒ Outpatient Therapy ❒ Psychological Evaluation | | |
| **CONTACT NUMBERS:** | Message ok? ❒ Yes ❒ No | |
| **ADDRESS:** | | |

## Parent or Legal Guardian Information:

| | |
|---|---|
| Name of Parent or Legal Guardian: | Address: |
| Contact Numbers: | |

## Payment Information:

| | | | | |
|---|---|---|---|---|
| Type of Insurance ❒ Medicare | ❒ BCBS | ❒ Other: | | GROUP# |
| If no insurance, household income: | | | | |
| Insurance ID# | | Phone # | | |

## Referral Source Information: Complete this section so we can contact you after the referral.

| | |
|---|---|
| Name | Mailing Address |
| Phone# | Email address |
| How did you hear about Serenity Psychological Services & Consulting LLC? | |

## Child/Adult Mental Health Information:

| | |
|---|---|
| Current medication & dosage | Current DSM-5 Diagnosis |
| | |
| | |
| | |
| | |
| Prescribing Physician name & Phone | |

| Current Mental Health Symptoms: | Unknown | Not Present | Mild | Moderate | Severe |
|---|---|---|---|---|---|
| Hallucinations (describe) | | | | | |
| Delusions | | | | | |
| Thought disorder | | | | | |
| Bizarre (psychotic) behavior (describe below) | | | | | |
| Anxiety / Nervousness | | | | | |
| Obsessive / compulsive | | | | | |
| Phobias / fears | | | | | |
| Depressed mood | | | | | |
| Mood swings | | | | | |
| Sleep disturbance | | | | | |
| Irritability | | | | | |
| Anger / temper tantrums | | | | | |
| Hyperactivity | | | | | |
| Attention deficit | | | | | |
| Eating problems | | | | | |
| Elimination problems | | | | | |
| Oppositional / defiant to those in authority | | | | | |
| Antisocial / delinquent behavior / conduct disorder | | | | | |
| Over sexualized behavior | | | | | |
| Somatic complaints with no known medical cause | | | | | |
| Attachment disorder (explain below) | | | | | |
| Other (explain) | | | | | |

**Reason for referral for treatment/Evaluation:** In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

_____

_____

_____

**Additional Comments** _____

_____

Been in counseling before?:_____

Availability: _____