



**NEW GENERATIONS**

**Referral Form (one referral per client)**

Client Information

Client name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender:  Female  Male

Address of Residence: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Emergency/Cell: \_\_\_\_\_

Culture: \_\_\_\_\_ Languages spoken: \_\_\_\_\_

Parent/Guardian Information:  N/A

Parent Name: \_\_\_\_\_ Legal Guardian (if different) \_\_\_\_\_

Clients Resides with:  Parent  Foster Parent  Court Placement  State Ward  Other : \_\_\_\_\_

Referral Source Information:  N/A

Referring Worker's Name: \_\_\_\_\_

County or Organization and Department: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Payment Information:  Insurance  Self-pay  Court order  EAP

Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Services Seeking:

Mental Health  Rule 25 (Chemical Dependency) Assessment

Current Symptoms: \_\_\_\_\_

Provider Considerations:

First Available (may not be a cultural or ethnic match)

No Preference

Specify: \_\_\_\_\_

Previous Assessments:  Yes  No if yes please bring to the initial appointment or fax with referral

Previous School IEP::  Yes  No if yes please bring to initial appointment or fax with referral

How did you hear about HSI- NewGenerations: \_\_\_\_\_