The Healing Center for Change, LLC

1827 Powers Ferry Road SE, Bldg. 14, Suite 250, Atlanta, GA 30339
www.HealingCenter4Change.org
(678) 800-1329

Child & Adolescent Client Referral Info Form

Today's Date:_____

Referral Agency/Contact:_____**Referral Phone #:** _____

Client's name:_____**Date of Birth**_____**Age:**____Gender: ☐ F ☐ M

Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other

Brief reason for seeking treatment: _____

Service(s) Requested: _____ Religious Affiliation (if applicable): _____

Address:_____City:_____State:_____Zip: _____

Home or Work Number_____Okay to leave a message? ☐ Yes ☐ No

Cell Phone Number_____ Okay to leave a message? ☐ Yes ☐ No

Cell Phone Carrier: _____ Email: _____

School _____ Grade level_____

Current Placement (residence) _____

Parent/Guardian Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Person_____Relationship to client:_____

Emergency Contact's Phone Number: _____

INSURANCE INFORMATION ~Please provide insurance card~ (Skip if self-pay)

Policyholder's Name_____Policyholder's SSN: - -

Date of Birth / / Primary Insurance Co. Name _____

Insurance Company's Customer Service Phone # _____

Insurance ID #_____Policyholder's Employer: _____

Group #_____Co-pay $ _____ Deductible? ☐ Yes ☐ No

Amount $_____ Authorization Required? ☐ Yes ☐ No

Authorization # _____ Number of Sessions Authorized _____

REASON you are requesting Behavioral/Mental Health Services? (Describe the problem(s))

_____

_____

_____

Additional Information needed for Intake (Required to process referral):

- ❑ Number in Family: _____ Family Income (If applicable/approximately):_____
- ❑ Child currently on medication? Yes or No (circle one). If so, name of med(s):_____
- ❑ Child on Probation? Yes or No (circle one). If so, number of arrest:_____ County: _____
- ❑ History of Substance Abuse? Yes or No (circle one). If so, name of substance(s):_____