



REACH HEALTH & WELLNESS INTAKE & REFERRAL FORM

Clinical services intake and behavioral-health referral.

Complete and print, or print to complete by hand.

Referral Information: Self-Referred ☐ Date: _____

Referral Source (Name): _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Client Information: Marital Status: _____ Race/Ethnicity: _____ Gender: _____ Age: _____

Client's Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Veteran ____ Yes ____ No Homeless ____ Yes ____ No

Parent/Guardian: _____ Address: _____

Day Phone: _____ Evening Phone: _____ Relationship: _____

Reason(s) for Referral _____

Recommendation(s) (select all that apply)

- ☐ PRP - Psychiatric Rehabilitation Program
- ☐ IOP - Intensive Outpatient Program
- ☐ Residential Treatment | Supportive Housing
- ☐ Employment Support Assistance (ESA)
- ☐ DWI/DUI Classes
- ☐ Therapy/Counseling
- ☐ Medication Management
- ☐ Psychiatric Evaluation
- ☐ Testimony Required
- ☐ Court/DSS Follow up
- ☐ Discharge from inpatient
- ☐ Other

Insurance Information:

- ☐ Medicaid
- ☐ Medicare
- ☐ Medicaid/Medicare
- ☐ None

Medicaid /
Medical Assistance# _____