FOUNDATIONS

Behavioral Health Services

4761 St. Rt. 29 ~ Celina, Oh 45822
Phone: 419-584-1000 / Fax: 419-584-1825

Referral Source: _____ Date: _____

Name: _____ DOB: _____

Address: _____

Phone Number: _____ Gender/Race: _____

Name of Parent/Guardian (if applicable): _____

Insurance: _____ Social Security #: _____

Is there Household Income? ☐ Yes ☐ No

Reason for Referral: _____

_____

_____

Family Constellation: _____

_____

Health Needs: _____

_____

Other Comments: _____

_____

_____

Is Person At Risk of Removal from Community/Home/School: ☐ Yes ☐ No

SERVICES DESIRED:

_____Psychological Evaluation/Testing

_____Mental Health Therapy Services

_____Mental Health Case Management

_____Med./Somatic Services

_____AOD Program

_____School Based Services

_____Intensive Home Based Services

_____Other

_____

DISPOSITION OF REFERRAL ~ For Office Use Only

Staff Processing Referral: _____ Date Client Contacted: _____

Open Access Hours Given: ☐ Yes ☐ No Notes: _____