INSIGHT
Therapeutic Services

Therapeutic Counseling Referral Form for DHR

Client Name:	DOB:	Age:
Address:	City:	Zip:
Contact Number:	SSN:	Medicaid Number:
Gender:	Ethnicity:	Marital Status:
Highest Completed Grade Level:	Employment Status:	Legal Status (number of arrests in the last 30 days)
Legal Guardian Name:	Relationship:	Email Address:

Referral Source:

Name & Agency:	Contact Number:	Email Address:

Reason for referral (Check all that apply):

☐ Behavior/conduct ☐ Emotional Mental Illness ☐ Independent Skills (ILP)
☐ Legal/Probation/court Mandated ☐ Social/Interpersonal Challenges ☐ Physical Abuse
☐ Sexual Abuse ☐ Neglect ☐ Emotional Abuse

Services Requested (check all that apply):

☐ Individual Counseling ☐ Family Counseling ☐ Group Supports ☐ Anger Management
☐ Trauma Recovery ☐ Sexual Abuse Counseling ☐ Behavior Modification Therapy
☐ Social/Interpersonal Skills ☐ Group Counseling ☐ Promotion of Wellness & Self-Management ☐ Arts Therapy ☐ Independent Living Skills

Symptoms and Behaviors of Risk: (check all that apply)

☐ Anxiety/Panic ☐ Adjustment Challenges ☐ Depressed ☐ Mood ☐ Psychotic Features
☐ Suicidal Ideations/ Attempts ☐ Homicidal Ideations/ Attempts ☐ Isolative Behaviors
☐ Hyperactive ☐ Manic Mood ☐ Impulsivity ☐ Physical Aggression ☐ Verbal Misconduct
☐ Unlawful Activity ☐ Self-Care Deficit ☐ Social Withdrawal ☐ Obsessions/Compulsions
☐ Physical Pain/Discomfort ☐ Changes In Sleeping Pattern ☐ Changes In Appetite

Presenting Problem:

Please attach most recent EPSDT screening with referral: ☐ (Check off that it is attached)

Insight Therapeutic Services Administrative Use Only:

Check off Once Completed	Date Completed
☐ Confirm EPSDT Copy Confirmed	
☐ Contact Referral Source and Client	
☐ Schedule Intake Meeting	Date of Meeting:

_____ _____

Intake Coordinator Printed Name Signature & Date