Family Health Center

Probation & Court Ordered Services Referral

Once completed, please send us this form along with a Release of Information form, any Legal documentation (Court Order and/or Affidavit), and Demographic Registration (Optional) to referrals@yourfhc.org. Please advise the person that is being referred, that having the Self-Assessment packet completed would allow them to be seen in a timelier manner.

Referral Information:

Agency Name: _____ Date: _____

Referring Agency Staff: _____
(Name) (Title)

Phone Number: _____ Email Address: _____

Address: _____
(Street) (City) (State) (Zip Code)

Client Information:

Full Name: _____ DOB: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone Number: _____

Contact Person if Minor: _____
(Name) (Phone Number) (Relationship)

Translation completed by: _____

Emergency Contact: _____

Probation/Court Ordered Service Information:

Case Number: _____

Start Date: _____ End Date: _____

Services Requested:

_____ Substance Abuse Evaluation

_____ Mental Health Evaluation

_____ Anger Management

_____ Primary Care

_____ Other: _____

See reverse side to complete insurance information →

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Insurance Information:

Does the client have Insurance (Circle one): Yes or No

Does the client have Medicaid (Circle one): Yes or No

If yes, which state is it through? _____

What is the client's Medicaid ID? _____

If not Medicaid, who is the insurance carrier? _____

What is the clients member ID? _____

What is the clients group number? _____

If insured through an employer, which employer? _____

If insured through an employer, who is the employee that carries the coverage?

_____

If not self, how are they related to the client? _____