



BAYS Community Care Counseling Referral Form

Demographic Information

Client Name:	DOB:	Age:	Date of Referral:
Address:		City:	Zip:
Contact Number:	SSN:		
Gender:	Race/Ethnicity:	Marital Status:	
Current/Highest Completed Grade Level:	Employment Status:	Legal Status (# of arrests in past 30 days):	
Legal Guardian Name (if applicable):	Relationship:	Contact Number:	

Referral Source

Name and Agency:	Contact Number:	Fax:	Email Address:
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Reason for Referral (Check all that apply):

<input type="checkbox"/> Behavior/Conduct	<input type="checkbox"/> Emotional Mental Illness	<input type="checkbox"/> Employment Instability	<input type="checkbox"/> Legal/Probation/Court Mandated
<input type="checkbox"/> Social/Interpersonal Challenges	<input type="checkbox"/> At Risk	<input type="checkbox"/> Substance Use/Abuse	<input type="checkbox"/> Educational Instability/Challenges
<input type="checkbox"/> Family Conflict	<input type="checkbox"/> School Behaviors	<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> Trauma
<input type="checkbox"/> Self-Injurious Behavior	<input type="checkbox"/> Step Down from Higher LOC	<input type="checkbox"/> Abuse/Neglect	<input type="checkbox"/> Other: _____

Services Requested (Check all that apply):

<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Family Counseling	<input type="checkbox"/> Group Supports Counseling	<input type="checkbox"/> Grief and Loss Counseling
<input type="checkbox"/> Recovery and Relapse Understanding	<input type="checkbox"/> Anger Management	<input type="checkbox"/> Trauma Recovery	<input type="checkbox"/> Sexual Abuse Counseling
<input type="checkbox"/> Behavior Modification Therapy	<input type="checkbox"/> Social/Interpersonal Skills Group Counseling	<input type="checkbox"/> Promotion of Wellness & Self-Management	
<input type="checkbox"/> Survivor Counseling	<input type="checkbox"/> Couples Therapy	<input type="checkbox"/> Mental Health Assessment/ Evaluation	<input type="checkbox"/> Other: _____

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

<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Adjustment Challenges	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Psychotic Features	<input type="checkbox"/> Suicidal Ideations/Attempts	
<input type="checkbox"/> Homicidal Ideations/Attempts	<input type="checkbox"/> Isolative Behaviors	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Manic Mood	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Physical Aggression

- Recreation services Verbal Misconduct Unlawful Activity Self-Care Deficit Social Withdrawal Obsessions/Compulsions
 Physical Pain/Discomfort Changes in Sleep Patterns Changes in Appetite Excessive Worry/Fear Grief Changes in Behavior
 Lack of Motivation Inattentive Poor Self-Image/Confidence Defiant Academic Challenges Change in Work Habits
 Hyperactive Manic Mood Impulsivity Physical Aggression Recreation services Verbal Misconduct Unlawful Activity
 Self-Care Deficit Social Withdrawal Obsessions/Compulsions Physical Pain/Discomfort Changes in Sleep Patterns
 Changes in Appetite Unlawful Activity Self-Care Deficit Other: _____

Please Discuss Presenting Problem:

Does the client have a history of receiving mental health services? *Yes (please describe below)* *No*

Is the client working with any other community-based providers? *Yes (please describe below)* *No*

Check all traumatic events that the client has experienced: *N/A*

- Witness or victim of domestic violence Victim of rape or sexual violation (abuse) Physical Assault Witnessing Violence
 Natural Disaster (hurricane, earthquake, flood, tornado, windstorm, wildfire, tsunamis, avalanche) Indicate what type: _____
 Serious Injury/Accident/Illness Witnessing a death War/Combat/Terrorism Incarceration
 Other: _____

Please Indicate Current Diagnosis (If Applicable and Known):

Diagnosis Code: (DSM-V): _____ Description: _____
 Diagnosis Given By: _____ Date: _____

Please List ALL Medications:

Does the client have transportation? Yes No (If no, how can we accommodate the client in order to receive counseling)

Prefer services in home Telehealth Provide services in the community
 Medicaid transportation Transportation provided by caregiver/guardian Other: _____

Primary Insurance Information:

Name of Insurance: _____ Plan Name: _____
Phone Number on Back of Card (Behavioral Health): _____ ID#: _____ Group Number: _____
Name of Insured: _____ Insured Date of Birth: _____

Referral to Include: (Please attach)

Social History Any Psychological/Mental Health/Substance Abuse Evaluation School Records
 Other: _____

BAYS Community Care Administrative Use Only

Verify Eligibility _____ Date Completed: _____
 Contact Referral Source and Client _____ Date Completed: _____
 Schedule Orientation and Intake Meeting: _____ Date of Meeting _____

BAYS Community Care Staff Printed Name

BAYS Community Care Staff Signature

Date

Questions or to make a referral call: Bays Community Care (407) 753-4240
Email Referral and/or attached documents to: BCC-Orange@bayskids.org