

Fax Referral Sheet/Phone Intake Form

Referral Date _____

Appointment request:

_____ Routine: Appointment scheduled within 2 weeks

_____ Priority: Appointment scheduled within 1 week, serious symptoms displayed

_____ Urgent: Appointment scheduled within a couple of days, treat as an emergency

Child Name: _____ Male Female

Address _____

City _____ State _____ Zip code _____

Phone Number(s) _____

Primary Insurance _____ Phone Number _____

Group#: _____ ID#: _____

Presenting Problems (check all that apply): suicidal thoughts/statements/attempts

acting sexually inappropriate adjustment difficulties anger problems anxiety

appetite problems depression being withdrawn changes in sleep patterns

fears emotional outbursts impulsivity inattention memory problems mood swings

problem behaviors psychotic thinking relationship problems thought distortion

worries

other: _____

Name and Title of Person Making Referral: _____

Phone Number/Contact Info: _____