THE COUNSELING SOURCE, INC.

FACILITY FAX REFERRAL SHEET/ PHONE INTAKE FORM

Phone: (513) 984-9838 (800) 618-0688 FAX: (513) 984-8075 (800) 738-9854

INCLUDE CLIENT FACESHEET and any Insurance Cards, Guardianship Court Order

PLEASE *COMPLETE* ***ALL FIELDS CLEARLY*** *AND WITH* ***DARK INK***

REFERRAL DATE: _____ **Telehealth: Yes____ No____**

_____ **ROUTINE: Appointment scheduled within 2 weeks**

_____ **PRIORITY: Appointment scheduled within 1 week, serious, non-urgent, symptomology displayed**

URGENT - DANGER TO SELF OR OTHERS. The Counseling Source (TCS) will respond immediately if a TCS staff member is on site at the time of the crisis. If there is no TCS staff person on-site then the host facility should dial 911.

FACILITY_____ **Room/Bed #** _____

Facility Address_____**City**_____ **State OH Zip**_____

Client Name_____ **Sex at Birth: Female____ Male____**

Date of Birth _____ **Social Security #**_____ **Pronoun: She____ He____**

Legal Guardian: No___ Yes___ Guardian Name _____ **Relationship**_____

Guardian Address _____ **City**_____ **State**_____ **Zip**_____

Email_____ **Skilled for Medicare Part A? Yes_____ No_____**

OHIO MEDICAID No____ Yes____ **Medicaid (MMIS) # (12 Digits)**_____

MCO Name (if applicable e.g. Caresource)_____ **MCO MEMBER ID**_____

PRIVATE INSURANCE (PI) PROVIDER: _____ **PI POLICY #:** _____

PI POLICY HOLDER NAME:_____ **PI POLICY HOLDER DATE OF BIRTH**_____

PRESENTING PROBLEM(s) ***Circle all that apply***

1. Suicidal Statements/Attempts	6. Appetite Problems	11. Emotional Outbursts	16. Problem Behaviors
2. Acting Sexually Inappropriate	7. Being Depressed	12. Impulsivity	17. Psychotic Thinking
3. Adjustment Difficulties	8. Being Withdrawn	13. Inattention	18. Relationship Problems
4. Anger Problems	9. Changes in Sleep Patterns	14. Substance Abuse	19. Thought Distortion
5. Anxiety	10. Fears	15. Mood Swings	20. Worries

21. Other_____

_____

NAME/TITLE OF PERSON MAKING REFERRAL: _____

PHONE#_____ **EMAIL**_____