

THE COUNSELING SOURCE, INC.
FAX REFERRAL SHEET/ PHONE INTAKE FORM

Phone: (513) 984-9838 (800) 618-0688

FAX: (513) 984-8075 (800) 738-9854

INCLUDE STUDENT FACESHEET and if Applicable: DASL Sheet, Insurance Cards, any Guardianship Papers**PLEASE COMPLETE ALL FIELDS CLEARLY AND WITH DARK INK**

REFERRAL DATE: _____

____ ROUTINE: Appointment scheduled within 2 weeks

TELEHEALTH: YES ____ NO ____

____ 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.

SCHOOL _____ GRADE _____ TEACHER _____

NAME _____ SEX AT BIRTH: FEMALE ____ MALE ____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ PRONOUNS: SHE ____ HE ____

ADDRESS _____ CITY _____ STATE OH ZIP _____

GUARDIAN NAME(s) _____ RELATIONSHIP _____

ADDRESS (if different) _____ CITY _____ STATE ____ ZIP _____

PHONE _____ EMAIL _____

HAS THE PARENT BEEN INFORMED OF THE REFERRAL? No ____ Yes ____

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 Being Withdrawn | 13.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 Use | 19. Thought Distortion |
| 5. Anxiety | 10. Fears | 15. Mood Swings | 20. Worries |
| 21. Other _____ | | | |

NAME/TITLE OF PERSON MAKING REFERRAL _____

PHONE NUMBER _____ EMAIL _____