

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, Guardianship Papers**PLEASE COMPLETE ALL FIELDS CLEARLY AND WITH DARK INK**

REFERRAL DATE: _____

 ROUTINE: Appointment scheduled within 2 weeksTELEHEALTH: 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 Being Withdrawn	13.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 _____