Lighthouse Child & Family Services

Referral Form

Chart # _____

Insurance Information

Name of Primary Client: _____ Date of Birth: _____ Race:_____

School Attending: _____ Grade/Teacher: _____

Address: _____ Phone #: _____

Insurance Company: _____ Date Insurance Began: _____

Primary Client Policy ID#: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Address: _____

Policy Holder ID#: _____ Group #: _____

Primary Client Lives With: _____

Family Information

Father's Name:_____ Date of Birth: _____ Race:_____

Address: _____ Phone #: _____

Mother's Name: ___ _____ Date of Birth: _____ Race: _____

Address: _____ Phone #: _____

Siblings Name:	Age:	Gender:	Resides with:
_____	_____	M F	_____
_____	_____	M F	_____

Reason for Referral:

_____

_____

_____

___ Diagnostic Assessment
___ Individual therapy
___ Family therapy
___ Couple/Marriage
___ CSP
___ ARMHS
___ Adult DBT Program
___ Adolescent DBT Program
___ School Linked Mental Health
___ Skills Training (CTSS)
___ Pre School Day Treatment
___ Supervised Parenting Time
___ Summer Skills Group

Current services and/or past services provided:

_____

_____

_____ _____ _____

Name of Individual Making the Referral Phone # Date

○ Yes, I need a copy of the DA

4/2017