

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Adult DBT Program | <input type="checkbox"/> Childrens/Adolescent Day Treatment |
| <input type="checkbox"/> Individual therapy | <input type="checkbox"/> Adolescent DBT Program | <input type="checkbox"/> Pre School Day Treatment |
| <input type="checkbox"/> Family therapy | <input type="checkbox"/> School Linked Mental Health | <input type="checkbox"/> Skills Training (CTSS) |
| <input type="checkbox"/> Couple/Marriage | <input type="checkbox"/> Intensive Treatment in Foster Care | <input type="checkbox"/> Summer Skills Group |
| <input type="checkbox"/> CSP | | |
| <input type="checkbox"/> ARMHS | | |

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