



Referral Form

Corporate Office: Phone (850) 769-6001 Toll Free 1-877-234-5351 Fax (850) 769-6003

Please check desired services _____ County of residence _____

Counseling _____ Psychiatric Services _____ Case Management _____ Partial Hospitalization Program _____

(Check)

Insurance type: Medicaid _____ PMHP _____ Medicare _____ Third party _____ Self pay _____

Primary insurance # _____ Secondary insurance # _____

Client name _____ Gender _____

S.S. # _____ D.O.B. _____ Age _____

Phone # (home) _____ (work) _____ (cell) _____

Address (street) _____ (City) _____ (Zip) _____

May we leave a message for you? Yes _____ No _____ If yes, which number _____

Guardian's name _____ Relationship to client _____

School _____ Grade _____ ESE _____ IEP _____

Mental health primary diagnosis: _____

Substance Abuse concerns? Yes _____ No _____ If yes, explain _____

Have you ever received services at FTS? Yes _____ No _____ When? _____ Where? _____

Current/prior mental health services _____

Reason for referral _____

How did you hear about FTS? _____

Name of person making referral

Agency name

Phone number

Date

FTS personnel taking referral

Office location

Office Use Only

FTS personnel receiving referral _____ Date referral received by FTS: ____/____/____

Referral sent to: _____ Date referral sent: ____/____/____

Date of contact with family: ____/____/____ Date of Medicaid verification: ____/____/____

Notes: _____