Center for Family & Child Enrichment, Inc.

BEHAVIORAL HEALTH REFERRAL FORM

1825 NW 167th Street, Suite 102 Miami Gardens FL 33056
Intake Department: (305) 305-624-7450 Ext. 1749
mhreferrals@cfceinc.org

SECTION I. INDIVIDUAL IDENTIFYING INFORMATION

INDIVIDUAL NAME: _____

MARITAL STATUS: _____ **DOB:** _____ **AGE:** _____

SOCIAL SECURITY NUMBER: _____ **INSURANCE & POLICY NUMBER:** _____

INCOME: _____ **FAMILY SIZE:** _____

FULL ADDRESS: _____ **ZIP CODE:** _____

PRIMARY PHONE NUMBER: _____ **ALTERNATIVE PHONE NUMBER:** _____

METHOD OF COMMUNICATION (SPECIFY): _____

Email: _____

EMERGENCY CONTACT NAME & PHONE NUMBER: _____

SEX (CIRCLE ONE): Male / Female **GENDER IDENTITY:**

☐ Male ☐ Female ☐ Transgender Male / Female-to-Male ☐ Transgender Female / Male-to-Female ☐ Choose not to Disclose

☐ Preferred Pronouns (specify): _____

SEXUAL ORIENTATION:

☐ Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to Disclose

RACE:

☐ Black or African-American ☐ White ☐ Hispanic ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese

☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ American Indian/Alaskan Native

☐ More than one Race ☐ Unreported/Chose not to Disclose Race

ETHNICITY:

☐ Hispanic/Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Not Hispanic/Latino ☐ Unreported / Refused to Report Ethnicity

☐ Another Hispanic or Latino (specify): _____

SECTION II. LANGUAGE / SPECIAL NEEDS:

Is the Individual Served Deaf or Hard of Hearing? ☐ Yes ☐ No **Visually Impaired?** ☐ Yes ☐ No **Proficient in English?** ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ French ☐ Other (Specify): _____

Religion (Specify): _____ **Are there any spiritual or religious beliefs or practices that should be considered in your treatment? If so, Specify:** _____

SECTION III. EMPLOYMENT INFORMATION

Current Employer: _____

SECTION IV. MENTAL & HEALTH HISTORY

MENTAL HEALTH HISTORY

Is the Individual receiving mental health services elsewhere? ☐ Yes ☐ No If Yes, Specify: _____

Does the Individual have a Psychiatrist? ☐ Yes ☐ No If Yes, Specify: _____

Is the Individual currently taking any medication for mental health reasons? If so, Specify _____

Would the Individual like to be contacted for Psychiatric and/or Psychological Services? ☐ Yes ☐ No If so, Specify _____

MEDICAL HEALTH HISTORY

Is the Individual receiving medical health services elsewhere? ☐ Yes ☐ No If Yes, Specify: _____

Does the Individual have a Primary Doctor? ☐ Yes ☐ No If Yes, Specify: _____

Is the Individual currently taking any medication for medical reasons? If so, Specify _____

Would the Individual like to be contacted for Medical Services? ☐ Yes ☐ No If so, Specify _____

SECTION V: LEVEL OF CARE NEEDS

Thoughts of Self Harm, including Cutting: ☐ Yes ☐ No If so, Explain _____

Thoughts of Harming others: ☐ Yes ☐ No If so, Explain _____

Previous Hospitalization: ☐ Yes ☐ No If so, Explain _____

Previous Arrest: ☐ Yes ☐ No If so, Explain _____

Sexualized Behaviors: ☐ Yes ☐ No If so, Explain _____

Alcohol and/or Drug Use: ☐ Yes ☐ No If so, Explain _____

Are there any past experiences that still affect the Individual that would need to be considered during treatment? ☐ Yes ☐ No If so, Explain _____

Please Describe the Reason for the Referral (*Some services may be subject to additional fees):

☐ Individual Therapy ☐ Family Therapy ☐ Outpatient Substance Abuse Therapy ☐ *Targeted Case Management

☐ *Psychiatric Services ☐ *Psychological Services ☐ *Anger Management Group, Specify: Child/ Adult ☐ *Domestic Violence (Victims)

☐ *Domestic Violence (Batterers Intervention Program) Other, Specify: _____

ADDITIONAL COMMENT: _____

_____

_____

Person Completing Referral **Signature** **Date** **Telephone Number**

For Intake Department Staff Use Only

☐ **Self-Referral** ☐ **Primary Care** ☐ **SMS or CINS/FINS** (CIRCLE ONE)	**Referral Date:** _____ **Processed Date:** _____ **Intake Date:** _____