3100 Lord Baltimore Drive, Suites 208-209 ▪ Windsor Mill, MD 21244
(Office) 410-701-7384 ♦ (Fax) 410-521-7005
Email: info@hclff.com ♦ Website: www.hclff.com

MENTAL HEALTH REFERRAL FORM

DATE OF REFERRAL: _____

Appt Date: _____
Appt Time:_____
Scheduled By: _____
ID#: _____
Distance: _____
Therapy Preference: ☐ **In-Home** ☐ **Office**

CLIENT DEMOGRAPHIC INFORMATION			
Client Name:	D.O.B.:	Age:	SS#:
Male ☐ Female ☐ Marital Status:	Employment Status:	Race:	Phone#:
Current Address:			
City/State:	Zip:		

PARENT/GUARDIAN INFORMATION *(if applicable)*		
Parent/Guardian Name:	(Relationship to client):	
Address:	City/State:	Zip:
Cell Phone#:	Alt. #:	

INSURANCE INFORMATION		
Primary Insurance:	ID#:	Effective Date:
Policy Holder: ☐ Self ☐Other: _____		
Authorization /Eligibility Verified By:		Date:

***IF CLIENT IS UNDER DSS GUARDIANSHIP, PLEASE COMPLETE THE INFORMATION BELOW**		
Social Workers Name:		
Address:	City/State:	Zip:
Work#:	Cell#:	Fax#:

Consent Attached? ☐Yes ☐No		
SCHOOL INFORMATION *(if applicable)*		
Name of Current School:	Grade Level:	Ph#:
Address/City/State/Zip:	Fax#:	
PRIMARY CARE PHYSICIAN INFORMATION		
Name:	Office Phone:	
Address/City/State/Zip:	Office Fax:	
MEDICAL HISTORY & INFORMATION		
Is The Client Currently Receiving Mental Health Services? ☐ Yes ☐ No		
Therapist Name, Facility & Contact#:		
Psychiatrist Name, Facility & Contact#:		
Are You Planning On Discontinuing Services With These Providers? ☐ Yes ☐ No If yes, reason		
Has Client Been Hospitalized For Psychiatric Treatment In The Past? ☐ Yes ☐ No		
If yes, Please Indicate Most Recent Admission:		
Is The Client On Any Psychiatric Medication? ☐ Yes ☐ No		
If yes, Name of Medication(s)		
Are Medications Prescribed By Psychiatrist or Primary Care Doctor?		
Any Medical Problems? ☐ Yes ☐ No		
Any History Of Substance Abuse? ☐ Yes ☐ No If Yes, Is Substance Use Active Or In Remission:		
Any History of Traumatic Brain Injury? ☐ Yes ☐No		
Any History Of Being Diagnosed With A Developmental Disorder? ☐ Yes ☐No		
If Yes, Please Indicate If Client Can Communicate Verbally: ☐ Yes ☐No		
Is There a Legal Guardian or Power of Attorney? ☐ Yes ☐No Name:		
Any Active Legal Concerns? ☐ Yes ☐No		
Why Are You Seeking Treatment Today?		

Please Give A Brief History Of Current Mental Health Concerns:

Name of HLF Staff Completing Referral Form:

REFERRAL SOURCE				
☐BCDSS ☐ DJS ☐ DHMH	☐VALUE OPTIONS	☐SCHOOL	☐FAMILY MEMBER	
☐THE M.A.T.C.H. PROGRAM	☐ W.I.N. FAMILY SERVICES	☐PARKER THERAPEUTIC SERVICES		
☐BCRC ☐CHILDRENS CHOICE	☐CHALLENGERS	☐DR. OKOJIE	☐DR. P. OHIKU	
☐OTHER				

Referred By (*Name and Contact# of person completing the form*):

For Office Staff Only

DISPOSITION		
Authorization#:	*Date of Authorization:*	*Of Units:*
Intake Completion Date:	*Diagnostic Evaluation Completion Date:*	
Psychiatric Evaluation Completion Date:	*Referral is scanned:* ☐Yes ☐No	
NOTES:		

****Please Fax All Pertinent Evaluations/Medical Records Along With This Referral****