C . O . A . C . H .
Counseling Outreach Advocacy Change Hope

C.O.A.C.H. Mental Health, LLC

Child & Adolescent Psychiatric Rehabilitation Program Referral

Please help us to efficiently process your referral by completing this document its entirety.

Date: _____ Consumer Name: _____
SS#: _____-_____-_____ DOB: _____/_____/_____ Sex: _____ Race: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____
Phone : _____ Alternate Number: _____
Physical Description: _____
School: _____ Current Grade: _____
School Services:
( ) IEP ( ) 504 ( ) Other: _____
Emergency Contact (Relationship to Consumer):_____
Contact's Phone: _____ Support for Client? Yes / No

Current Treatment Status
( ) Inpatient- projected release date: _____
( ) Partial Hospitalization- projected release date: _____
( ) Crisis Bed/Other crisis facility-projected release date: _____
( ) Outpatient
( )Date of most recent inpatient discharge:_____
( ) Other: _____

ICD-10 Diagnosis: _____
Additional Behavioral Health Diagnosis: _____
Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis (check all that apply):

( ) None
( ) Problems with access to health care services
( ) Housing problems (Not Homelessness)
( ) Problems related to social environment
( ) Educational problems
( ) Occupational problems
( ) Problems related to interaction w/legal system/crime
( ) Homelessness o Financial problems
( ) Problems with primary support group
( ) Other psychosocial and environmental problems
( ) Unknown

Presenting Problem/Current Symptoms
(attach most recent psychosocial assessment/evaluation if available):

_____

_____

_____

Reason(s) for referral (Check all that apply):

( ) Self-Care Skills
( ) Social Skills
( ) Independent Living Skills
( ) Conflict Resolution
( ) Anger Management
( ) Interactive Skills with Peers and Authority Figures
( ) Maintaining Personal Living Space
( ) Maintaining Personal Safety in Social Environments
( ) Time Management
( ) Other _____

Risk Assessment-Aggression, Homicide or Suicide(explain): _____

_____

Involvement Information: ( ) DJS ( ) DSS

Medicaid Number: _____ Date Applied or Active: _____

Other Income/Insurance: _____

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by C.O.A.C.H. Mental Health, LLC. ***This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)***

I, _____, refer _____

(Print Clinician's Name & Credentials) (Print Consumer's Name)

_____ _____

(Clinician's Signature) (Clinician's Phone Number)