Referral Form

4319 Covington Hwy, Ste 110. Decatur, GA 30035
404-286-0054 (O) 404-286-0064 (F)

Referral Source

Name of referring person: _____ Date of Referral: _____
County_____

Agency: Family____ DFCS____ School____ BHL____ PRTF____ Probation____ DJJ___ Other_____

Phone: _____ Fax: _____ Cell: _____

Email: _____Preferred Contact Method: Email___Phone___Cell__

Supervisor: _____ Phone:_____

Is Client aware referral is being made Yes_____ No_____

Client Information

Client Name: _____ Case ID# (if applicable): _____

DOB: _____ Gender: Male ___ Female___ Ethnicity: _____

Client's School: (If/A) _____ Current Grade Level: _____

Client' Employment: (If/A): _____

Current Placement: Biological Parent _____ Foster Placement____ Group Home___

Legal Guardians Name: _____

Current Address: _____

Phone Number: _____Cell Phone: _____

Mental Health Diagnosis: _____ Medications: _____

Medicaid #: _____ Social Security Number#: _____

Type: Medicaid/Insurance____ Peachstate/Cenpatico____ Amerigroup____ WellCare____ Georgia ASO _____ BC/BS____ Aetna ____UBH ____United Healthcare _____EAP Program *Uninsured_____

Has client had a psychological/psychiatric evaluation in the past 12 months? Yes____ No ____N/A _____

Behavior in last 3 months**:** Depression____ Anxiety/Stress_____ Relationship Issues____
Anger Issues_____ Runaway___ Physical Aggression____ Suicidal Ideation /Attempt _____
Verbal Aggression _____ Defiance_____ ISS/OSS_____ LegalInvolvement_____ Deprived_____
Sexual Acting Out_____ Self-Harming Behaviors_____ Other_____

****Please attach psychological/psychiatric or any discharge forms if available**

Thank You for Coming into the Marvelous Light

Open/Pending Court Case ____Yes ____No Court Date: _____ Court Part_____

Name: _____County: _____ Phone_____

DFCS Involvement: *Yes **____** No **_____** **DFCS** approval for services Yes ____ No____

If child is in the custody of DFCS please complete consent form

Caseworker: _____ Telephone #: _____

I _____, the case worker for _____ as guardian of said consumer, authorize the Foster Parent/FP Case Manager_____ For _____the authority to sign Marvelous Light Consultants legal and consent form's authorizing Community Behavioral Health Treatment Services.

Signature: _____ Date: _____

Status of Referral: (office only)

Accept Team: _____ Case Number: _____ Date: _____

Decline Reason: _____ Date: _____