BGTPS
Bridging Gaps Through Positive Solutions

PROGRAM REFERRAL FORM

Date of Referral:_____

Referral Source Information

Agency/Individual Name: _____ Title:_____ Phone #: _____

Address: _____ Fax #: _____

Email Address: _____

Consumer Information

Client Name: _____ Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____

Social Security #:_____ MA#:_____

Employer/School:_____ Highest Grade Completed:_____

Parent?Legal Guardian Name:: _____ Phone number: _____

Home Address: _____ Email Address: _____

Rehabilitation Services Needed:

- ❑ Coping Skills
- ❑ Social Skills/Peer Interaction
- ❑ Family/Natural Supports
- ❑ Medication Management
- ❑ Work/Job Performance
- ❑ Assertiveness/Self-esteem
- ❑ Behavior Interventions
- ❑ Activities of Daily Living
- ❑ Safety to self/others
- ❑ Legal Issues #of Arrest____
- ❑ Adult Vocational/Educational Skills
- ❑ School Performance
- ❑ Anger MGMT/Conflict Resolution
- ❑ Money Management
- ❑ Substance Abuse Issues

Current Treatment: Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates.

1.

2.

Diagnosis: please indicate current DSM V diagnoses.

ICD 10 Code: DSM V Code: _____

ICD 10 Code: DSM V Code: _____

Diagnosis given by:_____ Date: _____

Medications (Please provide name and dosage amount)

Date Received: Approve/Denied	Coordinator Assigned Assignment Date:	Authorization Dates:

Please forward the most recent assessment and/or treatment plan when sending this referral.

Printed Name and Credentials:

Date: _____ **Signature:**_____