TENDER TOUCH COUNSELING SERVICES, LLC.

REFERRAL/TRIAGE FORM

Part I: Client Information

How did you hear about us? Google Search Engine? ☐ Social Media (Facebook, Instagram)? ☐ Billboard? ☐
Magazine? ☐ Seen Our Vans? ☐ Referral? ☐ Other: _____

Date: _____

Name of Client: _____(LAST) _____(FIRST)_____(MIDDLE)

Date of Birth: _____ S.S.N: _____

Race: _____

Address: _____ _____

City: _____ State: _____ Zip Code_____

Telephone Number: _____

Medicare Number: _____

Other Insurance Name: _____ ☐ Insurance ID#: _____

Name of Caregiver/Contact Person: _____
Name of Facility (if applicable): _____

Part II: Referring Source

Name of referring person: _____

Agency *(if applicable)*: _____Telephone number: _____

Part III: Reason for Referral

Summarize reason(s) for admission, current diagnosis and treatment, and past history of mental health/substance abuse treatment:

_____
_____
_____
_____
_____

Part IV: Triage

Yes	No	
		Client actively suicidal or homicidal.
		Client has a primary behavioral health diagnosis.
		Client has been diagnosed with Intellectual Developmental Disabilities, Autism, Organic Mental Disorders, Traumatic Brain Injury, Dementia or Alzheimer's.
		Client is in active substance use withdrawal and requires detox.

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Medication Management? ◯ **Yes** ◯ **No**

Date Received: _____ Received By: _____

Insurance Active: ◯ Yes ◯ No ◯ Other: _____

Is this an Urgent or Critical referral? ◯ Yes ◯ No If yes, requires 24-48 hour turn-around to complete assessment.

Client name: _____ Date: _____