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: _____