Pathway to Hope Counseling Services, Inc.
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Child/Adolescent Intake Referral Form

Consumer Information:

Consumer's Name:	Date of Referral:
Type of Insurance: ☐ Amerigroup ☐ CareSource ☐ Medicaid ☐ Peachstate ☐ Wellcare	
Medicaid ID #:	Date of Birth:
Gender: ☐ Male ☐ Female	Age:
SS#:	Grade:
Name of School:	Race:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	
Consumer's Physical Address:	
City, State:	Zip Code:

Home Phone #:	Cell #:	Work #:
Parent/Guardian and Relationship to Client:		

What Other Services Sought:

1. Has the child had other services (e.g., Community Support Individual – CSI, Individual and/or Family Counseling?
   ☐ Yes ☐ No ☐ Not Sure
2. Does the child have a known Serious Emotional Disturbance and/or Substance Abuse Issue/Diagnosis?
   ☐ Yes ☐ No ☐ Not Sure
3. Are child and/or family issues in need of intensive, coordinated clinical and supportive intervention? ☐ Yes ☐ No
4. Is the child at immediate risk of out of home placement or is currently in out of home placement and re-unification is imminent? ☐ Yes ☐ No
5. Has Psychological/Psychiatric Evaluation been completed? ☐ Yes ☐ No *If yes, please attach.*
6. Does child present with autistic behaviors? ☐ Yes ☐ No *If yes, how severe?* ☐ Mild ☐ Moderate ☐ Severe

Referral Information:

Name & Title of Person Making Referral:	
Agency:	Court Mandated? ☐ Yes ☐ No County:
Phone # of person making referral:	Fax #:
Email of person making referral:	

Service(s) Requested:

☐ CORE-Medicaid Program (Individual/Family Therapy; Therapy for Substance Abuse (SA); CSI – Life Skills)

☐ Intensive Family Intervention	☐ Trauma Assessment	☐ Other

Presenting Problem:

List problem behaviors; include any medications for emotional and/or behavior problems.