

**Choices For Life of Georgia, LLC**  
**Behavioral Health Services Referral Form**  
**2200 N Patterson Street**  
**V: 229-244-1707 F: 229-244-1779**  
 (Completed by Applicant and/or Legal Guardian)

Date of referral: \_\_\_\_\_

Person Making Referral: \_\_\_\_\_ Contact Info: \_\_\_\_\_

<b>CHILD'S DATA:</b>			
<b>CHILD'S NAME:</b> (Print Clearly)	First Name	Middle Name	Last Name
<b>Date of Birth:</b>	<b>Age:</b>	<b>SS#:</b>	<b>Legal Status:</b>
<b>Race / Ethnic Group:</b>	<b>Gender:</b> Female <input type="checkbox"/> Male <input type="checkbox"/>		<b>Referred by:</b>
<b>Parent(s) / Legal Guardian / Emergency Contact Data:</b>			
Name: _____		Relationship: _____	
Physical Address: _____		City/ State/Zip Code: _____	
Home Telephone: _____		Cell / Other Telephone #: _____	
<b>Payor Source Data:</b>			
Payor Source: Medicaid <input type="checkbox"/> PeachState <input type="checkbox"/> Wellcare <input type="checkbox"/> AmeriGroup <input type="checkbox"/> CareSource <input type="checkbox"/>			
Insurance Policy Number: _____		<input type="checkbox"/> Private Insurance Name: _____	
<input type="checkbox"/> Tricare Sponsors Name: _____		DOB: _____ Policy#: _____	
<b>Services Offered/Requested:</b>			
<input type="checkbox"/> Individual/Family Therapy <input type="checkbox"/> Community Support Services <input type="checkbox"/> Group Services <input type="checkbox"/> Psychiatric Services <input type="checkbox"/> Trauma Assessment			
<b>Presenting Problems: (Problem Behavior, community involvement, previous treatment if known)</b>			
SA Issues: <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes; Substance Used: _____ Last Use: _____			
Recent ER Medical/MH Services (location--- type of services received):			

Medications currently prescribed/Prescribing Physician/ Pharmacy Used:  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Name of Current School attending? \_\_\_\_\_ Current Grade: \_\_\_\_\_

\*\*\*\*\*Official Use\*\*\*\*\*

Eligibility Results: \_\_\_\_\_ Date/Initials: \_\_\_\_\_  
 Initial Contact Date(s): \_\_\_\_\_ Method: \_\_\_\_\_ Initials: \_\_\_\_\_  
 Appointment Date/Time: \_\_\_\_\_ Referral Source notified: \_\_\_\_\_  
 Assessor: \_\_\_\_\_ Date/Initials: \_\_\_\_\_