Synergy Mental Health Services
Referral

Client Information

Name: _____ **Medicare #:** _____

DOB: _____ **Medicaid #:** _____

SSN: _____ **Emergency Contact:** _____

Address: _____ **EC Address:** _____

_____ _____

ZIP: _____ **EC ZIP:** _____

Phone: _____ **EC Phone:** _____

Alt #: _____ **Alt #:** _____

Client needs help with:

Therapy	☐ Anxiety	☐ Lack of Coping Skills	☐ Impulsivity	☐ Mood Swings
	☐ Aggressive Behavior	☐ Depressed / Sad Moods	☐ Obsession / Compulsion	
☐ Other :				
P S R	☐ Problem Solving	☐ Conflict Resolution	☐ Setting Goals	☐ Moral Reasoning
	☐ Communication skills	☐ Building Relationships	☐ Building Self Confidence	☐ Social / Personal Boundaries
B S T	☐ Time Management	☐ Organizational Skills	☐ Hygiene / Self Care	☐ Personal Safety
	☐ Home safety	☐ Cleaning / Laundry	☐ Cooking / Meal Planning	☐ Money Management
☐ Other :				
☐ Treatment Home	Needs housing within: ☐ 6+ weeks	☐ 4-6 weeks	☐ 2-4 weeks	☐ 1-2 weeks ☐ ASAP

Referral Source

Name: _____ **Agency:** _____

Relation: _____ **Address:** _____

Phone: _____ _____

Alt #: _____ **ZIP:** _____

Current Services

☐ Psychiatrist	☐ Case Manager	☐ PCA Service	☐ Day Treatment	☐ Therapy
☐ AA / NA	☐ PSR Services	☐ BST Services	☐ Other	

Current Medications (or attach list of medications)

Substance Use History

Substance Used	Date of Last Use

Food Allergies: _____

Medication Allergies: _____