COMPASSION CENTER
Hispanic Health Council
Phone # 860-7527-0856 ext. 1103
FAX # 860-761-0318

Hispanic Health Council
Un puente hacia una vida saludable y justicia social con compasión y apoyo.

REFERRAL FORM

REFERRAL SOURCE

Date of Referral: ______ **Referral Source**: ______
Name of person Referring : ______ **Phone Number** : ______
E-Mail : ______ **Address**: ______

DEMOGRAPHICS

Name: ______ **DOB**: ______ **SSN**: ______
Address : ______
City: ______ **State**: ______ **Zip code**: ______
Mobile Number : ______ **E-Mail**: ______
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Lives with Significant Other
Understands English? ☐ Yes ☐ No **Preferred Language**: ______
Employment: ☐ Yes ☐ No **Race**: ______ **Religion**: ______
Emergency Contact: ______ **Relationship**: ______
Assigned Sex at Birth: ☐ Female ☐ Male ☐ Declined to answer **Gender Identity**: ☐ Female ☐ Male
☐ Gender Queer ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Decline to answer

INSURANCE

☐ **Medicaid #** ______ ☐ **Medicare Carrier** ______ **Policy #**: ______
☐ **Commercial**: ______ **Policy #**: ______ ☐ **Uninsured**: ______

SERVICES

☐ **Individual Therapy** ☐ **Group Therapy** ☐ **Family Therapy** ☐ **Medication Management**
☐ **Couples Therapy** ☐ **Psychiatric Evaluation** ☐ **Other**: ______

PRESENTING PROBLEMS

SELECT ALL THAT APPLY

☐ Anxiety
☐ Depressed Mood/Sadness
☐ Hallucinations
☐ Sleep Changes
☐ Panic Attacks
☐ Crying spells
☐ Risky Behaviors
☐ Irritability
☐ Impulsivity
☐ Excessive worrying
☐ Racing Thoughts
☐ Avoidance
☐ Loss of interest
☐ Lack of concentration
☐ Other: ______

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HX OF TREATMENT

Does the client have the history of the following:

Substance Abuse/Methadone/Suboxone: ☐ Yes ☐ No **Suicidal/Homicidal Thoughts:** ☐ Yes ☐ No

If yes, please describe: ______

______

OP/IOP/PHP/IOL/Detox: ☐ Yes ☐ No

If yes, please describe: ______

Prescribed Methadone/Suboxone: ☐ Yes ☐ No

If yes, please describe: ______

HX OF MEDICAL

Does the client have the following:

PCP ☐ Yes ☐ No Where? ______

Behavioral Health Provider ☐ Yes ☐ No Where? ______

Current medications: (if no available spaces use a blank document)

Rx ______ Rx ______ Rx ______

Rx ______ Rx ______ Rx ______

Chief complaint/reason for referral: ______

______

______

INTERNAL REVIEW

Case Discussion: ______

______

Outcome: ______

Sliding Scale Approved on: ______ **Scale:** ______ **Pro Bono Approved on:** ______

Therapist Assigned: ______ **Date:** ______

More Information :
175 Main St Hartford
860.527.0856 Ext.1103
Fax: 860-761-0318
Behavioralhealth@hispanichealthcouncil.org

THANK YOU