REFERRAL FORM

www.mentalhealthgeorgia.com

Alliance for Change Through Treatment, LLC.
Attachment and Bonding Center of Atlanta, LLC.
3547 Habersham at Northlake, Bldg F
Tucker, Georgia 30084

PART I: REFERRING AGENCY/INDIVIDUAL INFORMATION

Referring Agency:	Date:
Referring Individual:	Contact #:
Contact email:	Fax #:

PART II: CLIENT DEMOGRAPHICS

Legal Name of Referred Client:		SSN:
D.O.B.:	Race:	Sex: ☐ Male ☐ Female
Adopted: ☐ Yes ☐ No	Medicaid # (if applicable):	Type:
Court Involvement?: ☐ Yes ☐ No	**What County:** (Mark X) ☐ **Dekalb** ☐ **Fulton** ☐ **Clayton** ☐ **Gwinnett**	**Next court date & time:** **Probation Officer (s) Name:**
Current placement of client/Who does client live with?:		
Current street address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Alternate Phone:
Parent/Guardian Name(s):		
Household size/# living at residence:	Total gross monthly income:	

PART III: CLIENT HISTORY

Current School:	Grade:	School Phone:
Days of school missed in the last 30 days: Explain:		
Currently using drugs?: ☐ Yes ☐ No	Frequency of use:	
First time used?:	Drug(s) used:	
Currently taking medication?: ☐ Yes ☐ No	Type of medication(s):	
History of hospitalizations:		
History of suicidal ideations:		
Has the client been previously treated for mental health? ☐ Yes ☐ No		
Is the client being referred for Reactive Attachment Disorder (R.A.D.) or Attachment resistant therapy? ☐ Yes ☐ No		
Is the client being referred to the **S.A.V.E**. Program? ☐ Yes ☐ No		
Presenting Problems:		
Kaleidacare ID: (Office Use Only)	Diagnostic Impression (Axis I, II, III, IV-GAF):	
Staff Only: Date/Time In _____	**Date/Time Entered _____**	**Staff Initial ______**

RETURN TO: REFERRALS@MENTALHEALTHGEORGIA.COM OR 678-406-9881 (FAX)

(Revised May 2011)