ATTACHMENT AND BONDING CENTER OF ATLANTA
ALLIANCE FOR CHANGE THROUGH TREATMENT

REFERRAL FORM

REFERRING AGENCY/WORKER____ DATE__________________

REFERRING AGENCY/WORKER EMAIL__________________________________PHONE:_______________________________

CLIENT LEGAL NAME____

COURT DATE & TIME________________________ ADOPTED? YES_____ NO_____ D.O.B._______________________ RACE_______________________

SEX: M____ F____ SSN___________-_________-___________ MEDICAID_________________________ TYPE___________________________________

CURRENT PLACEMENT OF CLIENT____

CURRENT ADDRESS OF CLIENT____

HOME PHONE______________________________ ALTERNATE PHONE_____________________________ CELL PHONE__________________________

CURRENT SCHOOL____ GRADE______________ SCHOOL PHONE______________________________

DAYS OF SCHOOL MISSED IN THE LAST 30 DAYS (EXPLAIN) ____

PARENT/GUARDIAN NAME(S) ____ EMAIL: ____

HOUSEHOLD SIZE (LIVING AT RESIDENCE) _________________________________ TOTAL GROSS MONTHLY INCOME_________________________

CURRENTLY ABUSING DRUGS: Y______ N______ FREQUENCY OF ABUSE____

HISTORY OF DRUG USE____

CURRENTLY ON MEDS: Y_____ N_____ MEDS / DOSAGE INFORMATION___________________________________

HISTORY OF HOSPITALIZATIONS____

HISTORY OF SUICIDAL IDEATIONS____

HAS THE CLIENT BEEN PREVIOUSLY TREATED FOR MENTAL HEALTH____

____ WHERE: ____

IS THIS CLIENT BEING REFERRED FOR REACTIVE ATTACHMENT DISORDER (R.A.D.) OR ATTACHMENT THERAPY: Y__________N___________

IS THIS CLIENT INVOLVED IN THE JUVENILE JUSTICE SYSTEM: Y______N______ CHARGES: ____

IS THIS REFERRAL FOR THE **(S.A.V.E.)** PROGRAM: Y_______ N_______ KALEIDACARE ID #____

PRESENTING PROBLEMS: ____

DIAGNOSTIC IMPRESSION: *(AXIS I, II, III, IV, V – GAF)* ____

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