

# 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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\_\_\_\_\_  
\_\_\_\_\_