Cultivate
BEHAVIORAL HEALTH & EDUCATION

REFERRAL FORM

I. CLIENT INFORMATION

Name _____ Date of Birth _____

Gender Identity: _____ Ethnicity: _____

Current Address: _____

Social Security Number: _____

Parent/Guardian (if minor) _____ Shared Custody? ___Yes __No

Home Phone: _____ Cell Phone: _____ Other: _____

May we leave a message? Home: ___Yes ___No | Cell: __Yes ___No | Other: ___Yes __No

Language(s) Spoken: _____

Religion: _____

School & Grade: _____

Employer & Email: _____

_____

II. INSURANCE

☐Medicaid ☐Wellcare ☐Humana CareSource ☐Passport ☒Anthem ☐Aetna
☐Private/Commercial Insurance Plan

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

III. RESPONSIBLE PARTY/GUARDIAN INFORMATION

Name _____ Date of Birth _____

Current Address: _____

Home Phone: _____ Cell Phone: _____ Other: _____

IV. REFERRAL INFORMATION

Who referred you to us? _____

Their address? _____

V. AREAS OF CONCERN

Please check all areas of concern that apply.

☐ Addiction	☐ ADHD	☐ Adoption
☐ Aggression (verbal, physical)	☐ Alcohol Use	☐ Anger Issues
☐ Anxiety	☐ Attention-seeking Behaviors	☐ Autism
☐ Behavioral Issues	☐ Beyond Control	☐ Body-image Issues
☐ Chronic Illness	☐ Chronic Impulsivity	☐ Chronic Pain or physical issues
☐ Chronic Relapse	☐ Codependency	☐ Coping Skills
☐ Death of family member/friend	☐ Depression	☐ Developmental Disorders
☐ Divorce	☐ Domestic Abuse	☐ Easily Distracted
☐ Eating Issues	☐ Emotional Disturbance	☐ Family Conflict
☐ Gambling	☐ Grief	☐ Hoarding
☐ Infertility	☐ Infidelity	☐ Intellectual Disability
☐ Internet Addiction	☐ Learning Disabilities	☐ Life Transitions
☐ Marital and Premarital	☐ Men's Issues	☐ Mood Swings
☐ Obesity	☐ Obsessive-Compulsive	☐ Oppositional Defiance
☐ Out-of-home Placement	☐ Parenting	☐ Parents' Divorce/Separation
☐ Peer Relationships	☐ Poor/deteriorating Hygiene	☐ Pregnancy, Prenatal, Postpartum
☐ Relationship Issues	☐ School Issues	☐ Self Esteem
☐ Self-Harming	☐ Sexual Abuse	☐ Sexual Addiction
☐ Sleep or Insomnia	☐ Spirituality	☐ Stress
☐ Substance Use	☐ Suicidal Ideation	☐ Teen Violence
☐ Trauma & PTSD	☐ Truancy	☐ Weight Loss
☐ Women's Issues	☐ Other_____	
☐	☐	

VI. SERVICE LOCATION PREFERENCE

Please indicate location preference:

Please note that not all offices provide in home or community services

☐Home (*where available*) ☐Office ☐School ☐Community (*where available*) ☐Telehealth

FOR OFFICE USE ONLY

☐Accepted ☐Rejected ☐Date Referral Received: _____