



Advantage Psychiatric Services, LLC Referral Form for Mental Health Services

Client Information:

Client Name: _____	DOB: _____	SS #: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	School & Grade: _____	
Services Requested: <input type="checkbox"/> Office-Based Outpatient	<input type="checkbox"/> School Based (if therapist is available)	
Service Location: <input type="checkbox"/> Cecil County Office	<input type="checkbox"/> School (if appropriate)	
Contact Numbers: _____	Message ok? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address: _____	Date of Referral: _____	

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian: _____	Address: _____
Contact Numbers: _____	Type of Setting: <input type="checkbox"/> Home <input type="checkbox"/> Group Home
_____	<input type="checkbox"/> Foster Home <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Other

Payment Information:

Type of Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Uninsured <input type="checkbox"/> Other
Insurance ID: _____

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name: _____	Mailing Address: _____
Phone#: _____	Email Address: _____
How did you hear about Advantage Psychiatric Services, LLC?	

Child/Adult Mental Health Information:

Current Medication & Dosage	Current ICD-10 Diagnosis(es)
Prescribing Physician name & Phone: _____	



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Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / Compulsive					
Phobias / Fears					
Depressed mood					
Mood swings					
Suicidal thoughts					
Sleep disturbance					
Irritability					
Anger / Temper Tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / Defiant to those in authority					
Antisocial / Delinquent behavior / Conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting. Is there a history of inpatient hospitalizations?

Additional Comments: