MINDGATE BEHAVIORAL SPECIALISTS, PLLC 803 TAYLOR AVE, HIGH POINT, NC 27260
(336) 689-3444 (336) 886-1421(fax) Rev 2014

PRIORITY: _**Low** (schedule when available) **High** (schedule as soon as possible) _**Emergency** (see now)

Date of Referral:_____ CONFIDENTIAL COUNSELOR REFERRAL FORM Date Received _____

[ ] Adult [ ] Child [ ] Male [ ] Female Age _____ Language _____

Client Name _____Grade/School_____
First MI Last

Parent/Guardian Name _____ Home Ph. ( )_____

Address: _____ City: _____ Zip Code: _____

Contact #: _____ Referred by:_____Other_____

DOB _____Client lives with: _____

Doctor name: _____Office name_____ Phone # _____

Other Professional/role _____Agency Name_____
Phone # _____ Fax#_____

Reason(s) for Referral- Problems/Concerns related to: *(Please check all that apply.)*

[ ] Dramatic change in behavior
[ ] Worries
[ ] Daydream/fantasizes
[ ] Grief
[ ] Fears
[Sadness
[ ] Always tired
[ ] Motivation
[ ] Inattentive
[ ] Withdrawn
[ ] Cries easily for age
[ ] Self image/confidence
[ ] Non-touchable/pulls away

[Nervous/anxious
[ ] Perfectionist
[ ]Aggression/Anger
[ ] Swearing
[ ] Fighting
[ ] Lying
[ ] Bullying
[ ] Disrespectful
[ ] Defiant
[ ] Hurts self
[ ] Impulsive/hyper
[Over Active
[ ] Easily distracted

[ ] Makes Odd Sounds
[ ] Stealing
[ ] Destruction of Property
[ ] Sexual Acting Out
[ ] Peer Relationships

[ ] Chews (paper/clothes/hair)
[ ] Social Skills
[ ] Personal Hygiene
[ ] Family Concerns
[Depressed/low mood
[ ] Trauma
[ ] Damage property
[ ] Hurt others

[ ] Absences
[ ] Tardy
[ ]Wk habits/organization
[ ] Lack Completion of Assignments/Homework

[] Academics
[ ] Drop out risk (H.S.)
[ ] Other _____

Clarify Referral Problem / History: _____

_____

_____

_____

_____

ACTIONS *taken by the person referring this client, if applicable:* *(Please attach copies of any interventions attempted)*

_____

_____

Have you contacted parent/guardian about your concern? Y/N Date: _____
Explain below the outcome of parent contact: _____

_____

What other services is client receiving and/or have tried/utilized (school, counseling, Intensive In-home etc.)?

_____

_____

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*Agency/Person Making Referral (not parent):*_____ *Date of Referral:* _____

Referral Agency Phone # _____ Referral Agency Fax # _____

Services being requested: [ ] Outpatient Therapy [ ] Family Therapy [ ] Group Therapy [ ] Trauma [ ] Substance Use

[ ] Check if no insurance

*Insurance*_____ *Member/group#*_____

Policy holder _____ *Relationship to Client*

Insurance Phone # _____ *Insurance Fax #* _____

Emergency Contact: _____ Home Ph. ( )_____

Work Ph. (___)
_____ Cell Ph. _____ Referred by: _____ Teacher Other _____

Relationship to Client_____

Additional Comments _____

MGBS Use Only

Assigned Provider: ***Appointment Date/time:***

Reason Client not scheduled:

***[ ]* Unable to contact [ ] Patient declined appointment [ ] other (please Specify)**

[ ] We have reviewed the referral information and our available services do not best meet the needs of the client.

Comments:

Staff: ***Date Completed:*** ***Date notified referring Provider:***

MINDGATE BEHAVIORAL SPECIALISTS, PLLC. Screening Form

Last Name First Name Middle Initial Maiden Name

Client: _____

Address: _____ Date of Contact: _____
City State Zip

Phone :(Home) _____ (Work or Cell) _____ Type of Contact: Telephone Face-to-face

Client SS # _____ Referral Source — Person, Agency, Address, and Phone:
Guardian _____ _____
_____

Age: _____ Birthdate: _____ Sex: M F

Occupation or school and grade: _____ Employer: _____

Marital Status: S M Sep D W Ethnicity: _____ Insurance: N Y Type: _____

Primary Language Spoken: _____ Medicaid # _____ Record # _____

Chief Complaint:

Presenting Problems (circle):

As reported by: Name _____ Relationship _____ Phone _____

Danger to Self: None. Thoughts of suicide, Threats of suicide, Thoughts of death, Suicide attempt, Inability to care for self, self harming behavior.
When? _____ Plan? _____

Past Danger to Self: None. Thoughts of suicide, Suicidal gestures, Suicide attempts, Family history of suicide. Inability to care for self:
When? _____ Method? _____

Danger to Others: None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to' care for others. When? _____ Plan? _____

Past Danger to Others: None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to care for others. When? _____ Plan? _____

Hospitalizations: **Mental Health:** Total admissions _____ Hospitalizations in the last 2 years? _____

SA Facilities: Total Admissions _____ SA Admissions in the last 2 years? _____

Seasonal Patterns? Yes No Describe _____

Relationship Issues: None. Conflict with peers, Siblings, Parents, Spouse, Significant other, Children. No/Few friends. Running away from home, Family desertion, Separation, Divorce, Visitation, or custody disputes, Child neglect, Child abuse, Spouse abuse.
(If Abuse, specify _____ . Death in family, No significant relationships. Other _____

Medical Problems: None. Disabled, Hearing impaired, Recent illness, HW, Hep C, Diabetes, Pregnant, Surgery, Other _____
Physician _____ Pharmacy _____ Number _____

Current Medications: 1. _____ 2. _____ 3 _____
4. _____ 5. _____ 6. _____

Substance Use/Abuse: Current Abuse:
Alcohol N Y describe _____
Amphetamines N Y describe _____
Benzodiazepines N Y describe _____
Narcotics N Y describe _____
Cocaine/Crack N Y describe _____
Marijuana N Y describe _____
Hallucinogens/Inhalants describe _____

Name: _____

Has Abused; Narcotics, Amphetamines, Hallucinogens, Inhalants, Marijuana, Cocaine, Crack, Alcohol, Benzodiazepines, Pain killers,

Other _____. Hospitalizations, Family problems, Job loss, Abuse related arrests. Other __

Assess need for detoxification if client is currently impaired/intoxicated_ Current pattern of *use* (what and how much): _____

Alcohol Level? _____ Date _____ Time Method Date of Last *Use* _____

Result: _____

What withdrawal symptoms has she/he had in the past?

DT's Blackouts Other _____

Current withdrawal symptoms: (circle those present) *If any symptoms exist, fill out the Medical Detoxification Screening Form* None.

Vomiting Sweating Agitation Tactile disturbances Auditory disturbances Visual disturbances Headache Tremors/Shakes

Depressive Symptoms: None. Sadness, Fatigue, Increased/Decreased Sleep, Increased/Decreased Appetite, Hopelessness, Loss of interest, Feelings of Worthlessness, Guilt, Agitation, Poor concentration, Crying, Anger, Social isolation, Irritability, Other _____

Anxiety: None. Anxiety, Conversion, Obsessions, Compulsions, Phobia, Multiple operations, multiple somatic complaints, Nightmares. Panic Attacks, Separation anxiety, Soiling, Other _____

Manic-Like Behavior: None. Euphoria, Over talkative, Sleep Loss, Grandiosity, Extravagance, Racing Thoughts, Other _____

Developmental Disabilities: None. TBI Head injury, Autism spectrum, Ambulatory, Verbal, Needs assistance with independent living skills, needs assistance with ADL's, Borderline intelligence, Mental retardation/mild/moderate/severe. Other _____

Psychotic/Organic Symptoms: None. Unmanageable, Inability to care for self, Memory deficits, Withdrawn, Wanders off, Poor personal hygiene, Does not make *sense,* Suspiciousness, Sleep loss, Poor judgment, Forgetfulness, Confusion, Auditory hallucinations, Visual hallucinations, Delusions, Disorientation, Other _____

Antisocial: None. Frequent lying, Stealing, Excessive fighting, Destroys property, Fire setting, Arrests, Convictions, Imprisoned, Sexually inappropriate, Exhibitionism, Uses assumed names, Acts alone in peer group, Probation, Parole, Pending charges, Physically cruel to animals, other _____

Education Difficulties: None. Behavior problems, Academic problems, Needs/receives special education, *Needs* technical training, Truancy, Drop out, Suspensions, Expulsion, Other _____

ADD or ODD: None. Hyperactivity, Impulse control, Attention span, Loses temper, Argumentative, Annoys others, Blames others, Other _____

Other Information: Homeless, Lives at shelter (which one?) _____ Lives with family/friends (Who?) _____ Phone #_____ Would you like someone to contact you about affordable housing information? Financial Stress, Unemployed, Receives disability income, Cannot afford medications. Transportation problems.

Summary/Comments: _____

Urgency Designation: Emergent (assess face to face within 2 hr.) Urgent (assess face to face within 48 hr.) Routine *(assess face to face* within 7 days)

Consumer Choice: Has this consumer been offered a choice of providers? Yes No

Choices offered and reasons for choice are documented in: Admission assessment, Chart, Other _____

Tentative Diagnosis: _____

Client to walk in and *seen* _____ on _____ at _____

Disposition: Client seen and given an appointment to return for _____ at _____

Client referred to another provider?, Provider Name _____

Appointment date and time _____

Clinician signature and credentials: _____

Agency: _____