Empowering Youth For Positive Change

"Empowering One Family at a Time"

REFERRAL INFORMATION

Email completed form Attn: Utilizations & Referrals to: referralsga@ey4pc.com

Date of Referral: _____________

Client Information

Client's Legal Name:___________________________ **Date of Birth:** ____________________________

Client's Preferred Name: ______________________ **Gender:** ☐ **Male** ☐ **Female**

Race: _______________________________________ **Pronoun Preferred:** ________________________

Sexual Orientation: ____________________________ **SSN #:** __________________________________

Client's Full Address: Address, City, State, Zip

____

Current Living Situation:

☐ **Parent(s)** ☐ **Other Relative/Guardian(s)** ☐ **Foster Parent (s)**

Client's School Name/Address:

Current Grade: _________

____

Primary Insurance Provider:

☐ **Amerigroup** ☐ **Care Source** ☐ **Medicaid** ☐ **Peach State** ☐ **WellCare** **Other:** _________________

Insurance ID #:_____________________________

Parent or Guardian's Name: _________________________________ **Relationship to child:** _________________

Contact #: _________________________ **Contact Email:** ____

DFCS/Court Involvement ☐ **Yes** ☐ **No** **Email:** ____

Contact Name: ____________________________ **County:** _______________ **Contact#:** _________________

ICD 10 Diagnosis: (must meet SED or substance related diagnoses)

____

Please email confirmed diagnosis (psychological, psychosexual, psychiatric, and/or trauma assessment) to referralsga@ey4pc.com or fax: **(470-239-2300)**

Current Medication:

Name/Dosage	Quantity	Frequency

Client Name: _________________________________

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Services Needed:

☐ In-Home Community Based Services ☐ Intensive Family Intervention

Additional Information Needed:

Has the child received individual therapy recently? (services will have to be discontinued by referral source to obtain authorization for IFI services.)

☐ **Yes, If yes include contact information: ____**

☐ **No**

Has the child been placed in a PRTF?

☐ **Yes, If yes include contact information: ____**

☐ **No**

Which of the following symptoms does the client display? Check all that apply)

☐ Suicidal

☐ Physically Self-Destructive

☐ Legal Issues

☐ Homicidal

☐ Specialized School Placement

☐ Substance Abuse

☐ Sexually Aggressive

☐ Psychotic

☐ Physically Aggressive

☐ Multiple Foster Homes

☐ Serious Runaway Behavior

☐ History of Significant Psychological Trauma

☐ Severe Somatization

☐ Other

Referral Source:

Name: ___________________________________ **Relationship:** ________________________

Email Address: ____________________________ **Contact #:** __________________________

Client Name: ___________________________________

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Reason for referral:

Justification and Circumstance for Requested Additional Services:

Goals for referral:

Current documentation required to assist with obtaining authorization for service (if applicable)

- ☐ Assessments: Psychological, Psychosexual, Trauma, Psychiatric
- ☐ Physical
- ☐ Dental
- ☐ Individual Education Plan (IEP)
- ☐ Report Card

Signature of Referring Personnel:____ Date: ___________

EYPC Staff Use Only

Verification of Insurance: _____________________________ **Assessor Assigned:** ___________________________

Date Assessment Scheduled: ___________________________ **Follow-up:** _________________________________

Client Name: ____