**Referral Form – Adult Day Treatment**

Please attach Diagnostic Assessment any other relevant Clinical Information

**Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referent Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Person Referring: |  | Referring Agency: |  |
| Phone Number: |  | Email: |  |

**Client Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | DOB |  |
| Street Address |  | Legal Gender |  |
| City, State, Zip |  | Email |  |
| Phone |  |  |  |
| *CLIENT INSURANCE INFORMATION* | | | |
| Insurance Primary |  | Policy # |  |
| Policy Holder (Name, Relationship & DOB) |  | Group # |  |
| Insurance  Secondary |  | Policy # |  |
| Policy Holder (Name, Relationship & DOB) |  | Group # |  |

Preferred Location: Oakdale Telehealth Day Treatment Track: Foundations DBT skills

Please describe why Adult Day Treatment services are indicated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe Client Goals/Motivation for Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Current Safety Plan(please attach) # Past Suicide Attempts: \_\_\_\_\_\_\_

Last Mental Health Hospitalization – When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Substance Use Treatment (if any) When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Treatment Providers:**

|  |  |
| --- | --- |
| Primary Care Physician & Clinic: |  |
| Psychiatrist & Clinic: |  |
| Individual Therapist & Clinic: |  |