Family's First
2 W. Rolling Crossroads Unit 109, Catonsville, MD 21221

Consumer Name: _____ Referral Date: _____

Referring Therapist: _____ SSN: _____

DOB: _____ Age: _____ Male: ____ Female: _____ Ethnicity: _____

Marital Status: Single: ___ Married: ___ Separated: _____ Divorced: _____

Education Level: _____ Arrested/Legal Issues in Past 30 Days: Yes___ No____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Phone: _____ Emergency Contact: _____ Relationship _____

Insurance Name: _____ ID# _____ Expiration: _____

Other Insurance? Medicare: _____ BCBS: _____ HMO/Other: _____

Services Requested: Therapy: _____ Medication: _____ Outside Services (PRP?) _____

Service Needed (check all that apply)

____ **Depressive Symptoms** ____ **Trauma/Domestic Violence** ____**Anger Problems**

____ **Anxiety Symptoms** _____ **Hyperactivity/Impulsivity** _____ **Substance use/abuse**

____ **Grief/Loss** _____ **School Problems** _____ **Thoughts of self-harm/others?**

____ **Legal Issues** _____ **History of psychiatric hospitalizations**

Last known medications: _____

Last known medical problems: _____

Contact Notes:

_____

_____

_____

OFFICIAL USE ONLY:
Insurance Status: Approved/Denied (circle) #visit:___ Auth Date: _____
Authorization #: _____ Staff Initials: _____