Shrewsbury Youth and Family Services, Inc.

REFERRAL FORM (rev. 4/16)

Primary Client Name: **Client Guardian Name (if applicable):** **Name of person calling in referral:** **Relationship to client:**	**Address:** **City/Town:**
DOB: **Age:** **Gender:** ☐ Male ☐ Female ☐ Transgender	**Preferred #:** **Leave message?** **Alternative #:** ☐yes ☐no **Email:**
How did you hear about SYFS? **Preferred Clinician Gender:** ☐ Male ☐ Female ☐ No Preference **Days and times available for appointments:**	**Type of Service Requested (Check):** ☐ Ind. Counseling ☐ Afterschool Program ☐ Family Counseling ☐ Case Management ☐ Couples Counseling ☐ Groups ☐ Bereavement Group ☐ Other (specify):
Insurance Company: _____ **Subscriber's Name:**_____ **Card #**_____ **D.O.B.**_____ **Employer name:** _____ **Provider Services or Behavioral Health # on back of card:** **Secondary Insurance?**	***SYFS OFFICE USE ONLY:*** Co-pay/Client Fee _____ # of initial sessions:_____

Chief Complaint/Presenting Problem: reason seeking services now, preferably in client's own words. If not, state where information came from. Is client at immediate risk of hurting self/others? ____No ____Yes (If yes, please specify immediate risk and provide referral source with emergency information.

Collateral Contacts / Providers

Doctor/PCP's Name: PCP Phone #:	State Agency Contact: (DCF, DMH, DYS, Probation, Transitional Assistance, etc.)
Counselor (s) / Therapist: Last seen:	School Contact: Phone #:

FORM FILLED OUT BY:_____ **DATE:**_____

SYFS OFFICE USE:

STATUS: WAIT LIST? IF YES, DATE PLACED: _____ **CLINICIAN ASSIGNED:**_____