DATE OF 1st CALL:

CENTRAL VIRGINIA PREFERRED PROVIDERS

Referral Form for Out-Patient Services

Client Information

Name:	Date of Birth:	SSN:
Gender: ❒ Male ❒ Female ❒ Couple	School & Grade:	
Services Requested: ❒ Office-Based/Outpatient Therapy ❒ Medication/Psychiatric Services		
❒ Psychological Evaluation ❒ Substance Abuse Services		
Insurance Company: _____	**Insurance #** _____	
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about CVPP?	

Child/Adult Mental Health Information:

List current medication & dosage	**Current DSM-V Diagnosis:**

Prescribing Physician/Pyschiatrist name & Phone					
Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Hallucinations (explain below)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional /defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic (body) complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child's/adult's need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

_____

_____

_____

Additional Comments: _____

_____

Been in counseling before?: **YES** **NO**

Availability:_____