Gray Matters Counseling

"Getting to the Heart of the Matter"

REFERRAL INFORMATION

Email completed form to: admin@graymattersatl.com

Phone: 404.883.0612/Web: www.graymattersatl.com

Date of Referral: __________ Person/Agency Referring:___________________ Contact:_______________

Client Information

Client's Legal Name: **Client's Preferred Name:**	**Date of Birth:**
Gender: ○ **Male** ○ **Female**	**Race:** ______________________________ **Sexual Orientation:** __________________________ **Pronoun Preferred:** __________________________
Current Living Situation: ○ **Parent(s)** ○ **Other Relative/Guardian(s)** ○ **Foster Parent (s)**	**Client's Full Address: Address, City, State, Zip**
Client's School Name/Address:	**Current Grade:**
Client's Employer Name/Address	**Occupation:**
Primary Insurance Provider: ○ **Amerigroup** ○ **Care Source** ○ **Medicaid** ○ **Peach State** ○ **WellCare** ○ **Other:** _________________________	**Insurance ID #:** **SSN #:**

Name of Parent or Guardian:	**Relationship to child:**	**Contact #:** **Contact Email:**
DFCS/Court Involvement ○ **Yes** ○ **No**	**Contact Name:** **County:**	**Contact #:** **Contact: Email:**

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ICD 10 Diagnosis:

____

- ○ **Please email confirmed diagnosis (psychological, psychosexual, psychiatric, and/or trauma assessment) to:** admin@graymattersatl.com.

Current Medication:

Name/Dosage	Quantity	Frequency

Services Needed:

Individual Therapy, Family Therapy, Group Therapy, Skills Training, Community Linkage

Additional Information Needed:

Has the client received individual therapy recently?

- ○ **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

Client Name: ____

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Referral Source:

Name/Relationship:	**Contact #:**	**Email Address:**

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: __________

GMC Staff Use Only

- **Verification of Insurance:**
- **Date Assessment Scheduled:** **Assessor Assigned:**
- **Follow-up:**

Client Name: ____