*\*Please send referrals to: Sarah Davinsizer, LSW, Clinical Supervisor*

Email: sdavinsizer@evolutionblair.com

 Phone #: (814) 201-2751 Fax #: (814) 201-2758

|  |  |  |
| --- | --- | --- |
| **DATE OF REFERRAL**  | **REFERRAL SOURCE NAME** | **REFERRAL CONTACT #** |
|  |  |  |
| **MEDICAL ASSISTANCE # or PRIMARY INSURANCE PROVIDER INFO** |
|  |

|  |
| --- |
| **PRIMARY CLIENT** |
| **FULL NAME** | **DOB/ AGE** | **SSN (if applicable)** |
|  |  |  |
| **STREET ADDRESS** | **CITY, STATE, ZIP CODE** |
|  |  |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
|  |  |  |
| If child/adolescent, who has legal custody of the client? |  |
| Where does the client currently reside? |  |

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| **REASON FOR REFERRAL** |
| **ADDITIONAL REFERRAL INFORMATION (i.e. is this a veteran, pregnant woman, any additional concerns, etc.)** |
| **CLIENT & FAMILY STRENGTHS** |
|  |
| **SERVICES CURRENTLY INVOLVED WITH CLIENT/FAMILY** |
|  |
| **SUBSTANCE USE AND/OR MENTAL HEALTH DIAGNOSIS** |
| Diagnosis Explanation: |
| Prescribed Medication: |
| **FAMILY & HOUSEHOLD** |
|  |
| **Parent or Guardian (if youth)/Spouse or Partner Name** | **Relationship** | **Age** |
|  |  |  |
|  |  |
| **Parent or Guardian (if youth)/ Spouse or Partner Name** | **Relationship** | **Age** |
|  |  |  |
| **History of substance use, violence, or mental health involvement?** |  |
| **Key supports for the child/adult?** |  |