SARAH'S HOUSE MENTAL HEALTH SERVICES LLC.

Date of Referral:______________________

Client Information

Client Name: ____________________ Date of Birth:_____________ Gender: ☐ Male ☐ Female ☐ Other:_____________________Pronoun Set:___________Race/ Ethnicity: ________________________
Age:_________ MA #: ________________________ Social Security #: _____________________
Parent/ Legal Guardian Name: _______________________Foster Parent: ☐Yes ☐ No (if yes submit copy of court order)
Is the client experiencing homelessness? ☐Yes ☐ No **Home Address**:
____
Is the client currently enrolled in an educational program?☐Yes ☐ No, Highest grade completed _______
If yes, School Name ____
Is the client currently employed? ☐Yes ☐No If yes, Where____

Military History: _________ Branch of Military: _________________ Tours of Duty:_____________________
Number of Arrests in last 30 days: _______ Number of Arrests in Last 12 mos._________________
Number of Dependent Children: ____________
Physical/Medical Disabilities: (ex. Difficulty hearing, speaking, talking, walking etc.)
____
Best Number to Contact: _________________ Email address: ______________________________
Best mode and time to contact: ____

Requested Service(s):

☐ Mental Health Evaluation/Assessment
☐Individual Therapy
☐Group Therapy
☐Psychiatric Rehabilitation Services(PRP)
☐Psychiatric Services/Medication Evaluation/Medication Management *(if requesting medication evaluation only, most recent Biopsychosocial evaluation is needed from current provider*)
☐Substance Use Services if yes,

- ➢ Drug of Choice: _____________________ Last Used: ______________________
- ➢ How Often: (ex. 1x/wk., 3-5x/wk. 1x/mo. etc.) ________________
- ➢ How Much: (ex.$10.00 worth, 2 12oz. beers etc.) _________________
- ➢ Withdrawal Symptoms: Y/N? _________________________
- ➢ Longest Period of Abstinence: ______________________ Age of first use:__________

Is the client currently on any medications? ☐Yes ☐ No
If yes, please list all medications and dosages____
Has the client recently been discharged from an Outpatient Mental Health Facility/ Hospital: ☐Yes ☐ No

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Reason for Referral/Presenting Problems (please be specific and include the previous diagnosis of possible
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____
____
____
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Referring Person Name and Title:

Please email all referrals to omhc@sarahshousemhs.com or info@sarahshousemhs.com or fax to: 410-225-3104 with supporting documents.

SARAH'S HOUSE
MENTAL HEALTH SERVICES LLC.

Referring Organization, Address, Phone E-mail Address:	
Referring Signature:	**Date**:

Office Use Only:

Therapist Preference: ☐Male ☐ Female ☐ No Preference

Service Type Preference: ☐ Individual ☐ Group ☐ Family

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