Pathways
Transition Programs, Inc.

120 East Trinity Place • Decatur, GA 30030 Phone (404) 378-2300 • Fax (404) 378-2394

REFERRAL FORM

DATE:

If other than self-referral or caregiver referral

REFERRAL SOURCE	Name:	Agency:
Phone #:	Fax #:	E-mail Address:

CLIENT INFORMATION			Male Female
First Name:	**Last Name:**		**DOB**:
Social Security #:	Insurance Name and Number:		
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:
Name of School:			

If the client is a child or adolescent, please complete the following

CAREGIVER #1 INFORMATION		Relationship to Child:	
First Name:	Last Name:		DOB:
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:
CAREGIVER #2 INFORMATION		Relationship to Child:	
First Name:	Last Name:		DOB:
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:

Do the caregivers have full custodial rights to make medical and educational decisions for this child?	Yes	No
Is there another parent or caregiver with joint custody we should inform about treatment?	Yes	No
Does the client have thoughts of self-harm or of harming others?	Yes	No
Does the client have an urgent or critical medical condition?	Yes	No
Does the client have a safety threat?	Yes	No

Reason for referral? Other Comments?			
Requested Services:	Counseling	Medication Management	Diagnostic/Assessment