Trinity Services, LLC

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Referral/MH/SA Screening Form

Referral made by:	Date:	Time:
Referral Source Email:	Phone:	
Referral received by:	Date:	Time:

Service Requested	Referral Method:
☐ Multisystemic Therapy	☐ In Person
☐ Outpatient Therapy	☐ By Phone
☐ Substance Abuse Intensive Outpatient Program	☐ By Fax
☐ Intensive In-Home Services	☐ By E-mail
☐ To Be Determined	☐ Other:

Safety Concerns at time of referral:

Consumer is: ☐ in crisis and needs immediate crisis intervention

Consumer is: ☐ in danger of hurting himself/herself ☐ in danger of hurting others

Presenting Problem(s)/Reason for Referral:

Consumer Information

NAME	Middle Name	LAST NAME/FAMILY NAME	MAIDEN NAME (Female only)

Date of Birth	Sex	Race/Ethnicity	Primary Language	Marital Status	Number of Children
	☐ Male ☐ Female	☐ Caucasian/White ☐ AA/Black ☐ Native American ☐ Hispanic ☐ Bi-Racial ☐ Other:	☐ English ☐ Spanish ☐ Other:	☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Other:	Minor children: Adult Children:
Age					

Social Security Number	☐ **Medicaid** ☐ **Health Choice** ☐ **BCBS** ☐ **Medicare** ☐ **VR** ☐ **IPRS** ☐ **Other**
	ID Number:

Consumer's Street Address	City	State	Zip Code

Cell Phone	Home phone	Work Phone

Parent/Legal Guardian (if applicable)

☐ Parent ☐ Legal Guardian ☐ Parent with Legal Custody (Please Submit Court Documents when Applicable)

Name	Middle Name	Last Name	Maiden Name

Street Address (If different from Consumer's)	City	State	Zip Code
(☐ Mark box if same as above)		NC	

Cell Phone	Home phone	Work Phone
(☐ Mark box if same as above)	(☐ Mark box if same as above)	(☐ Mark box if same as above)