**Illuminated Direction, LLC**

6116 Rolling Road Suite 104 Springfield, VA 22152

Office: 571-730-8445 F: 571-206-1049 Email: infova@idmindhealth.com

**Referral Form**

**Client Name:** **Medical Assistance #:**

**SSN**: **M or F Ethnicity: DOB: \_\_\_\_\_ Age:**

**Address: City: ZIP:**

**Home Phone: Cell Phone: Work Phone:**

**Legal Guardian (if applicable): Relationship (to client) Phone**

**REASON FOR REFERRAL (check all that apply):**

* Behavior/Conduct Challenges
* Emotional/Mental Illness
* Employment Instability
* Financial Instability
* Legal/Incarceration
* Medication Mismanagement
* Physical/Emotional Abuse
* Relational Conflicts
* Sexual Abuse
* Social/Interpersonal Challenges
* Substance Abuse
* Suicidal/Homicidal

**SERVICES REQUESTED (check all that apply):**

* Adaptive Resources
* Crisis Intervention
* Dangerous Behaviors
* Education-/Vocational Training
* Health Promotion
* Independent Living Skills
* Promotion of Wellness, Self-Management & Recovery
* Recovery Challenges
* Psychiatric Inpatient/Detention Center Support
* Self-Care Skills
* Social Relationships & Leisure Activities
* Social Skills

**SYMPTOMS AND BEHAVIORS/RISK BEHAVIORS (check all that apply):**

* Anxiety/Panic
* Attachment Problems
* Depressed
* Fire Setting
* Homicidal Ideations
* Hopeless/Helpless
* Hyperactive
* Impulsive
* Irritable
* Isolative
* Lying/Manipulative
* Manic Mood
* Obsession/Compulsion
* Oppositional Defiant
* Physical Aggression
* Property Destruction
* Running Away
* Self-Care Deficit
* Self-Injurious Behavior
* Separation Problems
* Sexually Inappropriate
* Social/Withdrawal
* Stealing
* Suicidal Ideations
* Trauma-related
* Truancy
* Verbal Aggression

\***FOLLOWING SHOULD BE FILLED OUT IF BEING REFERED BY A MENTAL HEALTH PROFESSIONAL**

**Please indicate current DSM V diagnoses & relevant medications: \_\_\_\_\_\_\_\_**

**Primary Medical Diagnosis Code:**

**Diagnosis given by (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_→ credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Treating Therapist Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Signature/Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicaid Information:**

Does the individual have an active Medicaid number? **Yes         No**

If no, has the individual been released from incarceration within the past 30 days?  **Yes         No**