



1559 Johnson Rd., NW
Atlanta, GA 30318
Main: 404-792-0070
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Core Services Screening/Referral Form

Name: _____ Today's date: _____

Address: _____ Date of birth: _____

_____ Gender/Race: _____

Consumer's SSN: ____/____/____

Insurance Co.: _____ Insured's ID #: _____

Parent/Custodian/Legal Guardian Name: _____ Contact Phone: _____

Initial contact person (if different from above): _____ Phone#: _____

Presenting Issues: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Medication | <input type="checkbox"/> Psychiatric Hospitalization |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Runaway | <input type="checkbox"/> Violence - Authority |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Sexually Acting Out | <input type="checkbox"/> Violence - Peers |
| <input type="checkbox"/> Homicidal/describe | <input type="checkbox"/> Suicidal/describe below | |

Past Behaviors: _____

Legal Status: _____

DFACS involvement: _____

Currently Receiving Outpatient Services: Yes No
(If yes describe) : _____

Current Diagnosis (if applicable): _____ Who provided diagnosis? _____

Current Medications: _____

Medical Conditions: _____

Office Use only

Intake Date/Time: _____

No appointment scheduled/Referred to: _____

Therapist assigned: _____