***Clermont County Board of Developmental Disabilities***

**Mental Health Support and Services Program**

**Referral Form**

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| **Client:** | | |  |
| **DOB:** | **SSN:** | **Medicaid #:** | |
| **Copies of past psychological assessments or diagnostic assessments and releases of information for psychiatrist, please attach if possible (may be received at a later date)** | | | |
| **Concerns that prompted the referral:** *(Note: behavioral and functioning problems, precipitating factors; services sought)* | | | |
| **Previous MH diagnoses and MH treatment history and client’s level of participation and expectations:** | | | |
| **Client’s level of commitment to participation in the program:**  **High**  **Medium**  **Low** | | | |
| **The ability to understand and apply the concepts from therapy. Explain:** | | | |
| **Is the client able to read and write:**  **Yes**  **No** | | | |
| **Method of communication used:** | | | |
| **Does the client have a legal guardian:** **Yes**  **No**  **If yes, then name of guardian and whether they can attend appointment:**        **Yes**  **No**  **Guardian contact info:** | | | |
| **Will the client need any special accomodations or interpreters?:**  **Yes**  **No** | | | |
| **Signature, relationship and phone nuber of person making referral:** | | | |
| **Date:** | | | |