***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:**  |