**All About Change Referral Form**

**Phone: (864)509.0774**

**Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| Client Name DOB Age Gender |
| Street Address |
| City State Zip |
| Parent / Guardian Name (if under 18 y.o.)  |
| Preferred Contact # Email |
| Insured’s Name SS#Insurance CompanyInsurance Telephone # Group# Member # |
| PCP PCP Contact # |
| Treatment Authorization # |

**Referring Provider / Agency**

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| --- |
| Agency Name or Self-Referral Phone Fax |
| Referral Contact Name email: |

**Required Information**

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| --- |
| Current Diagnoses or History |
| Presenting Problems |
| Services Requested (Circle all being requested Note -If client does not meet medical necessity services will not be authorized or provided)**Core Services:** Comprehensive Diagnostic Assessment CALOCUS Medication Management Psychosexual AssessmentPsychotherapy - Individual Psychotherapy - Family Group Psychotherapy Multi-Family Group Therapy Crisis Intervention Targeted Case Management **Community Support:** PRS Bmod Family Support   |
| Medical Conditions |
| List Current Meds |
| Legal Status |

**Please fax this form to: 1-877-629-7598 or email to: Kristian@allaboutchange360.com**

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| **All About Change Use Only** |
| **Referral Accepted**: If not accepted list practitioner or agency to whom the referral was forwarded |
| **Assigned Provider: Date of Initial Contact: Appointment Date:**  |
| **Reason Client NOT Scheduled****Unable to contact Client declined referral Authorization denied AAC cannot best meet service need \*** |
| **Comments \* Reason client was referred out** |

**06072019**