Community Outreach Services
2133 Silverside Dr., Suite F
Baton Rouge, Louisiana 70808
Phone: 225.250.5677 Fax: 225.444.5209

Referral/Screening Form

DEMOGRAPHIC:
Date of Referral: ____________________________
Client Name: ____________________________________ DOB: _____________ Age: _______ Grade: _____

Gender: Male Female Other: __________ Race: _________ Marital Status: ______ Ethnicity: ________

Medicaid Number: ________________________________ Bayou Health Plan: ______________________________

Social Security Number: ______________________________

Parent/Guardian Name: _________________________________ Relationship: ____________________________

CONTACT INFORMATION:

Phone Number: _____________________________ Alternate Phone: __________________________

Address: ____

City: _______________________________ State: __________ Zip Code: ______________

EDUCATION: Is the client enrolled in school? YES or NO

School Name: ____

PRESENTING PROBLEM(s): Please check all that apply

__ Anxiety
__ Criminal behavior (such as stealing, breaking into houses and vandalism)
__ Constant restlessness
__ Cutting Self
__Defiance (not wanting to do what they are told)
__ Depression
__ Destructiveness (e.g., destroying property)
__ Difficulty concentrating
__ Fidgety
__ Fighting
__ Fire-setting
__ Forgetting instructions
__ Hitting or biting themselves
__ Hurting pets or other animals
__ Low self-esteem
__ Lying
__ Phobias
__ Running away
__ Suicidal
__ Talking back or arguing with parents/teachers
__ Temper tantrums
__ Verbally threatening others
__ Substance Abuse

Other: ____

PAST TREATMENT:

Has the client been diagnosed with a behavioral or mental disorder in the past? ______

If "Yes", what was it? ____

Was the client prescribed any medication for this diagnosis? _____ If "yes" what kind? ____________________________

Has the client ever been enrolled in another agency/program? ___________ If "yes" where? ___________________________

Referral Source: ____

Passed Initial Screening?

☐ Passed
☐ Denied. Will make outside referral