MID-ATLANTIC
BEHAVIORAL HEALTH

DFS Referral Form

Name:

Date of Birth:

Worker:_____ Phone:_____

Fax:_____

Patient Contact Info (in case worker can not be reached in emergency):

1. Please indicate the type of battery to be performed:

☐ Partial (Clinical Interview + parenting questionnaire + personality questionnaire)

☐ Full (Clinical Interview + parenting questionnaire + personality questionnaire + IQ)

Please indicate the reason for involvement with DFS:

2. Please indicate prior mental health history (if any) and diagnoses:

☐ No prior mental health history

☐ Yes (please indicate type)

- ☐ Partial/Intensive Out-patient (IOP)
- ☐ Inpatient
- ☐ Outpatient

3. Please list names of medications (if any):

4. Criminal History (current and prior):

☐ None

☐ Yes (please explain)

5. Substance Abuse History (current and prior):

☐ None

☐ Yes (please explain)

6. What are the specific questions DFS would like answered related to the client's mental health (within the realm of this assessment)?