



Referral for Off-Site Therapy Services

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 4303 Forbes Boulevard, Lanham, MD 20706
 1301 W Washington Street Suite 101 Hagerstown, MD 21740
 Telephone: 301.790.0572 | Fax: 443.773.5624



Date of Referral: _____

Referral Source Information:

Name	Agency
Phone#	Email address

Client Information:

Name:	Date of Birth:	
Medical Assistance (MA) Number:	*Social Security Number*:	
Gender:	Telephone Number:	School/Grade:
Address:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Number:	
Email Address:	

Please answer the following:

Is the consumer of Hispanic, Latino, or Spanish origin?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unavailable
Race:	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Not Available
How well does the consumer speak English?	<input type="checkbox"/> Well <input type="checkbox"/> Not so well <input type="checkbox"/> Not at All
Does the consumer speak another language other than English at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the language?	<input type="checkbox"/> Spanish <input type="checkbox"/> Other
Number of Arrests in the Past 30 days?	<input type="checkbox"/> None <input type="checkbox"/> 1-99

Reason for referral for treatment: In your own words, describe the child/adult in need for therapy services. Please describe specific behaviors the child/adult is exhibiting. Please specifically note any of the following whether current or a history of: Recent Hospitalizations, Suicide Attempts or Ideation, Self-Harm, Aggression or Violence towards others, Domestic Violence, Psychotic Symptoms, Substance Abuse, Behavior Problems, & Mood Related Symptoms
