Empowerment Behavioral Health, LLC
Behavioral Health Assessment
Referral Form

Name:_____ Date: _____
Social Security #: _____
DOB:_____ Age: ____ Gender:____ Race: _____
Address:_____
_____
Telephone Number: (_____)_____-_____ (H) County of Residence:_____
(_____)_____-_____(C)
Guardian: _____ Relationship:_____
Address (if different than above): _____
_____
Alternative Telephone Number(s): (_____)___-_____
(____)____-_____
Any previous substance abuse treatment episodes, including failed attempts, completed programs, etc.?_____
_____

Is this assessment court ordered? ____Yes ____ No
If yes, date of next court appearance: _____

List previous and current offense(s):
_____
_____
_____

Is client currently enrolled in school? ___Yes ___No or GED Candidate ___Yes ___No
Current Grade: _____ High School /GED completion date:_____

Is client currently employed? ___Yes ___No If yes, part-time____full-time____
Employment: _____

Reason for referral: _____
_____
_____

Case Manager: _____
Telephone Number(s): (_____)_____-_____

Referring individual: _____Date of referral:_____
Telephone Number(s): (_____)_____-_____

In addition to the above-mentioned information, we request that you attach copies of all previous psychological and/or psychiatric reports and subsequent findings. In particular, we request prior Bio-psycho-social assessment information if available at the time the referral is made. This will expedite the process and ensure proper diagnosis and referral to the appropriate level of care/treatment if warranted.

12/2019