RusMed Consultants, LLC

Client Intake/Referral Form

Referral Completed By: ____ Referral Date: ______________

Referral Source: ____ Contact: ______________________________________

Phone: ___________________________________ E-Mail: ____

Have Referrals been made to other agencies? ☐ Yes ☐ No

Client Name: ____ Medical Record #: _______________________

Address: ____ DOB: __________ Age: _____ Race: _______

____ SSN#: ________________________________

Phone: _______________________ Other: _____________________ Medicaid #: ________________________________

Parent/Legal Guardian: ____ Relationship: _____________________

Address: ____ Phone: ________________________________

____ Other: ________________________________

Reason for Referral: ____

____

Diagnosis:

Code	Description
Axis I __________	____
Axis II __________	____
Axis III __________	____
Axis IV __________	____
Axis V GAF = ____________________	**Target Population:** ___________, ____________, _____________

Services Requested:

☐ B3-Respite
☐ CLS
☐ Community Networking
☐ Crisis Response
☐ Respite
☐ Residential Supports Level___
☐ Supported Employment
☐ Other: ____

Agency: ____ Service: ____

QP/CM/Therapist: ______________________________________ Contact Info: ____________________________________

Agency: ____ Service: ____

QP/CM/Therapist: ______________________________________ Contact Info: ____________________________________

Status of Referral:

Date Contacted: ____________ ____________ ____________ Date of Admission: ____________

Date Refused Service: ______ Reason: ____

Case Opened By: ____ Service Provided: ______________