REFERRAL FORM

18441 NW 2nd Ave Suite 216
Miami Gardens, FL 33169

www.less4you.com info@less4you.com

Information & Referrals: 305-501-4943 or 1-800-518-1962 - Fax: 888-793-9311

Referral Source Information

Date of Referral
Agency Name
Recipient Referred by
Phone Fax

Recipient Demographics

Name
SSN Date of Birth
Gender: ☐ Male ☐ Female
Address
City State
Zip Phone

Parent/Legal Guardian Information

Guardian's Name
Address
City State
Zip Phone
Recipient's School

Does Guardian Have Legal Documentation? Yes ☐ No ☐
School Phone
By Parents
Languages Spoken
Living Arrangements

Services Requested

In Office:

- ☐ Psychiatric Evaluation
- ☐ Medication Management
- ☐ Psychological Testing
- ☐ Psychosexual Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Family Therapy

- ☐ Adult Day Care
- ☐ Aged/Disabled Adult Medicaid
  - ☐ Waiver Program
- ☐ Substance Abuse Services
  - ☐ Outpatient
  - ☐ Day Treatment-Adolecents
  - ☐ Intensive Outpatient

In Home:

- ☐ Therapeutic Behavioral On-Site (TBOS)
- ☐ TBOS/Therapeutic Support Services (TBOS/TSS)
- ☐ Targeted Case Management

Note:
Please attach all assessments and background information available.

Please provide in detail the reason for referral:

Recipient's Financial Information

Medicaid Number
Other Insurance
Member Number
Bill to
Eligibility Ck by

Office Use Only

Date Received Time
Received Via: Email ☐ Fax ☐ Phone ☐ Walk-in ☐ Other ☐
Assigned Screener
Record No. Assigned