ATROYPEN GROUP INC.

REQUEST FOR SERVICES

Referral Status: **[ ] Urgent 2-hr response [ ] Emergent 24-48 hr response [ ] Routine 7 day response**

Last Name: _____ First Name: _____ Age: _____ D.O.B.: _____

SSN: _____-_____-_____Gender: [ ] Male [ ] Female Ethnic Group: _____
Primary Language: [ ] English [ ] Spanish [ ] Creole [ ] Other: _____

School Attendance: [ ] Yes [ ] No School Name: _____ Grade:_____
School Status: [ ] Passing [ ] Failing [ ] Truant [ ] Drop Out [ ] Suspended [ ] Other: _____

[ ]Parent/[ ]Legal Guardian: _____ Home Phone: (____) _____-_____
(attach proof of legal guardianship) (Last Name, First Name)
Cell Phone: (____) _____-_____

Address: _____ City/St: _____ Zip Code: _____

Insurance Information: Name of Insured: _____

Insurance Company Name: _____Insurance ID #: _____

Services Requested: [ ] Detox [ ] Res 1 [ ] Intensive Outpatient Therapy [ ] Psychosocial Rehabilitation
[ ] Psychiatric Evaluation [ ] Case Management [ ] Outpatient Therapy
[ ] Personal Supports [ ] Companion Services

Are requested services mandated by court? [ ] Yes [ ] No If yes, Case Number: _____

Probation Officer: _____ Telephone: (_____) _____

Presenting Problems:_____

_____

_____

Person Making Referral/Agency: _____

Telephone: (_____) _____ **FAX: (_____) _____**

Recipient/Parent/Guardian Printed Name:_____Signature:_____Date:_____

My signature verifies consent to gather information for a referral for services from DCOA.

For Office Use Only: **MR#:_____**
[ ] Insurance/HMO/PPO: _____
[ ] Insurance Verification Date: _____ Verifier Initials:_____
[ ] Referral transferred to Case Manager: _____

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