

**Orion Family Services
6333 Odana Road
Madison, WI 53719**

Date: _____

Referral To: **IN-HOME THERAPY MA/SED PROGRAM**

REFERRING AGENCY/INDIVIDUAL

Name of Agency/Individual _____
Contact Information: Phone/Address _____

IDENTIFYING INFORMATION

Client's Name _____ DOB _____
Current Residence _____
City _____ State _____ Zip _____ Tel# _____
Parents are: Married Separated Divorced Never Married
 Adoptive Remarried Mother or Father Deceased

MEDICAL ASSISTANCE Yes/No If yes, MA# _____ Type/HMO: _____

Other Insurance: Patient ID# _____
 Group# _____
 Name of subscriber _____

HEALTHCHECK Completed? Yes/No Attached? Yes/No

PARENTS

Mother _____ DOB _____
Street Address _____
City _____ State _____ Zip _____ Tel# _____
Place of Employment _____ Work# _____

Father _____ DOB _____
Street Address _____
City _____ State _____ Zip _____ Tel# _____
Place of Employment _____ Work# _____

Step-parent _____ DOB _____
Street Address _____
City _____ State _____ Zip _____ Tel# _____
Place of Employment _____ Work# _____

Court Ordered Referral? Yes/No (if yes, please attach report)
Date of expiration of order _____

PRESENTING PROBLEM(S)

TREATMENT HISTORY

Client: _____

Client Diagnosis: _____

Client Current Medications: _____

Family: _____

Client Involvement with Other Providers: _____

SCHOOL

School attending or last attended: _____

Contact person: _____ Grade: _____

Special Education: _____

School concerns (include academic, social and attendance): _____

Court involvement and law violations: _____

Out of Home placement within the previous 12 months:

Relationship (mother, father, siblings, peers):

Family background of domestic violence, child or sexual abuse:

Alcohol or other drug abuse of client and family:

Background of mother (psychological or pertinent medical history):

Background of father (psychological or pertinent medical history):

TREATMENT GOALS

Individual Goals: _____

Family Goals: _____

Availability for sessions:

Comments:

Please attach photocopies of any pertinent **COURT REPORTS, PSYCHOLOGICAL, PSYCHIATRIC, SCHOOL TESTING OR OTHER REPORTS** that would assist us in determining the appropriateness of the referral.