REFERRAL FORM

ACADEMY at GLENGARY
1819 Glengary Street
Sarasota, FL 34231
Tel: (941) 921-9936
Fax: (941) 922-2133

Membership Requirements:
1. **Referral Form signed by licensed clinician**
2. **Psychiatric Evaluation (most recent)**

PROSPECTIVE MEMBER INFORMATION

______________________________ **(name)**

______________________________ **(date of birth)**

______________________________ **(address)**

______________________________ **(social security number)**

______________________________ **(city)** **(state)** **(zip code)**

______________________________ **(phone number)**

DIAGNOSIS

Primary Dx:	
Secondary Dx:	
Tertiary Dx:	
GAF (if known):	

Traumatic Brain Injury	☐ yes ☐ no
Autism Spectrum Disorder	☐ yes ☐ no
Developmental or Intellectual Disability	☐ yes ☐ no

Reason for Referral/Goals:______________________________
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RISK ASSESSMENT:

BEHAVIOR	HISTORY	CURRENT ACTIVITY LEVEL			
violence	☐ yes ☐ no	☐ none	☐ minimal	☐ moderate	☐ high
suicide attempt(s)	☐ yes ☐ no	☐ none	☐ minimal	☐ moderate	☐ high
alcohol/drug abuse	☐ yes ☐ no	☐ none	☐ minimal	☐ moderate	☐ high
sexual exploitation	☐ yes ☐ no	☐ none	☐ minimal	☐ moderate	☐ high

Describe any legal involvement:______________________________
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Additional comments:______________________________
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PSYCHIATRIST INFORMATION - PLEASE FILL OUT COMPLETELY

______________________________ **(name)**

______________________________ **(phone)**

______________________________ **(address)**

______________________________ **(date)**

______________________________ **(city)** **(state)** **(zip code)**

signature

(use additional paper, if necessary, for any aspect of this referral form)