# SOUTH CAROLINA BHHS

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## Intake Referral Form

**Please Print Clearly** **Date of Referral:** _____

**Consumer Information:**

Consumer Name: _____
Type: ☐Regular SC Medicaid - Medicaid # _____
Date of Birth: _____ Age: _____ School _____ Grade Level_____
Gender: (Please Check) ☐Male ☐Female Race: _____ PCP: _____
Consumer's Address: _____ SSN:_____
City_____ State _____ Zip _____
Home Phone#: _____ Cell #: _____ Work #: _____
Parent/Guardian: _____

**What Other Services Sought:**

1. Has the child had other services (e.g. Behavior Modification BMOD, PRS, Individual and /or Family Counseling)? ☐**Yes** ☐**No** ☐**Not Sure**
2. Does the child have a known Serious Emotional Disturbance and/ or Substance Abuse issue/diagnosis? ☐**Yes** ☐**No** ☐**Not Sure**
3. Are child and/or family issues in need of intensive, coordinated clinical and supportive intervention? ☐**Yes** ☐**No**
4. Is the child at immediate risk of out of home placement or is currently in out of home placement and re-unification is imminent? ☐**Yes** ☐**No**
5. Has Psychological/Psychiatric Evaluation been completed? ☐**Yes** ☐**No** **If yes, please attach**

**Admission Status (Please Print):**

**Name & Title of Person making referral:** _____
**Agency:** _____ **Court or DSS Mandated? Yes or No County:** _____
**Phone # of person making referral:** _____ **Fax number:** _____

**Service (s) Requested (Please Check):**

☐ Community Support Services (Individual/Family Therapy; Therapy for Substance Abuse (SA); BMOD - , PRS - Life Skills, Family Support, etc.)
☐ Intensive Family Preservation ☐Other _____

**Presenting Problem:**

(List problem behaviors; include any medications for emotional and/ or behavior problems)
_____
_____
_____

***For Company Use Only:***

***Receipt Date:*** _____ ***Insurance Active Yes No Medicaid Plan:*** _____

***Assigned To:*** _____ ***Date Assigned:*** _____