ViaQuest
Psychiatric & Behavioral Solutions

REFERRAL/INTAKE FORM

ALL SECTIONS MUST BE FILLED OUT TO PROCESS REFERRAL
Call Intake at 855-289-1722 if you need assistance filling out this form.

Referral Date: _____ Region: _____

TYPES OF SERVICES REQUESTED:

- ☐ Medication Management (DD/IDD Deaf Diagnosis Only)
- ☐ Office Counseling
- ☐ In Home Counseling (Medicaid Only)
- ☐ TBS/Case Management (Medicaid Only)
- ☐ Psychiatric Nursing (Medicaid Only)

DEAF SERVICES:

- ☐ Deaf
- ☐ DeafBlind
- ☐ Deaf Low Vision

Contact for scheduling appointment: ☐ Client/Guardian ☐ Referral Source ☐ Other

Client Name: _____ Email Address: _____

Client Address: _____

City: _____ Zip: _____ County: _____

Cell Phone: _____ Client Home Phone: _____

Client Date Of Birth: _____ Male ☐ Female ☐ Other: _____

Social Security #: _____ Parent/Guardian Date of Birth (If Client Under Age 26): _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed

Ethnicity:
- ☐ Dominican
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

Race:
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Decline

Emergency Contact/Relationship: _____ Phone: _____

Client Has Legal Guardian: ☐ Yes ☐ No Name Of Agency (If Guardian): _____

Guardian: _____ Phone Number: _____

Guardian Email: _____

Fill out insurance information below or send a copy of your insurance card along with your referral.

Primary Insurance: _____

ID#: _____ Group#: _____

Secondary Insurance: _____

ID#: _____ Group#: _____

Referral Source: _____

Referral Source Phone/Fax/Email: _____

Any Hospital Stays In The Past 7 Days: ☐ No ☐ Yes (If Yes, Please Send Hospital Discharge Paperwork)

Does this client have a developmental disability or traumatic brain injury diagnosis? ☐ Yes ☐ No

Presenting Problem: (List Below Why Client Should Be Seen)

CHECK ANY CURRENT MENTAL HEALTH SYMPTOMS:

- ☐ Hallucinations
- ☐ Delusions
- ☐ Paranoid
- ☐ Anxiety
- ☐ Nervousness
- ☐ Obsessive/Compulsive
- ☐ Phobias/Fears
- ☐ Mood Swings
- ☐ Irritability
- ☐ Sleep Disturbance
- ☐ Depressed Mood
- ☐ Anger
- ☐ Hyperactivity
- ☐ Attention Deficit
- ☐ Eating Problems
- ☐ Oppositional/Defiant
- ☐ Behavioral Issues
- ☐ Delinquent Behavior
- ☐ Over Sexualized Behavior
- ☐ Physical complaints with no known medical cause
- ☐ Other