Universal
Therapeutic Center, Inc.

5602 Baltimore National Pike, Suite 204, Catonsville, MD 21228; **Phone:**443.315.5143, **Fax:** 443.315.5345. **Email:** info@utcenter.net

REFERRAL FORM

Referral Date: ___________

I. Consumer Information

Consumer Name: ________________________________ SS#: _______________

DOB: _____________ Male: _____ Female: _____ Ethnicity: ______________________

Marital Status: Single _____ Married _____ Separated _____ Divorced _____

Educational Level: __________________________ Arrest in past 30 days: Yes _____ No _____

Address: ____ City: ________________________

State: _____ Zip Code: ____________________ Phone: ____________________________________

Emergency Contact: ______________________________________ Relationship: ______________

Phone#: ___________________________ PCP Name: _________________________________

II. Insurance Information

Insurance Name: _____________________________________ Insurance #: ____________________

Expiration: ________________________

III. Referral Source Information

Referral Source (self, parent, hospital): ____

Name/Agency: ____

Name of Contact Person: ________________________________ Phone: _________________

REASON FOR REFERRAL: (check all that apply)

_____ Depressive Symptoms _____ Trauma/Domestic Violence _____ Anger Problems

_____Anxiety Symptoms _____ Hyperactivity/Impulsivity _____ Substance Use/Abuse

_____ Grief/Loss _____ School problems _____ Homicidal or Suicidal

_____ Legal Issues _____ History of Psychiatric Hospitalizations

Last Known medication(s): ____

Last Known medical problem(s): ____

OFFICIAL USE ONLY:				
Insurance Status:	Approved/Denied	Visits:	Date:	Staff Initials:
Intake Staff Assigned:				

UNIVERRSAL THERAPEUTIC CENTER, INC.
TEL: 443-315-5143 FAX: 443-315-5345

REFERRAL FORM

DATE: ________________________ **PROGRAM: PRP ON/OFF SITE:** ________ **MENTORING:** ________

Client's Name: ________________________ DOB: ________________ Age: ______
Address: ________________________ City: ________________ State: ______ Zip __________
Home phone: ________________ Other phone: ________________ Male: ________ Female: ________
Social Security# ________________ MA# ________________ Ethnicity: ________________
Marital Status: Single ______ Married ______ Separated/Divorced ______ Remarried ______ Veteran: Yes _____ No ______
Hurricane Katrina Victim: Yes ______ No ______

LEGAL CUSTODIAN (for minors/dependents):
***NOTE: Court documentation regarding custody status must be included with referral form.**
Primary DSS or DJS Custody? Yes ______ No ______ N/A ________ Court ordered attached to referral (if yes) ________

Name: ________________________________ Relationship: ________________

Work Phone#: (________)________________ Home #: (________)________________

Address: ________________________ City: ________________ State: ______ Zip: __________

REFEERAL SOURCE:
Agency: ________________________ Contact Person/Credentials: ________________
Phone: (_______)______________ Ext: ________ Other: (______)______________ Fax: (______)__________
Address: ________________________ City: ________________ Zip: __________

(Referrals to PRP Must be active in mental health treatment and approved by that provider)
MOST RECENT MENTAL HEALTH TREATMENT: Currently being treated? Yes ________ No ________
Agency: ________________________ Therapist Name/Credentials: ________________
Address: ________________________ City: ________________ Zip: __________
Phone: (______)______________ Ext: ________ Other: (______) ______________ Fax: (_____)__________
Therapist e-mail address: ________________________________

DSM IV DIAGNOSIS *NOTE: MUST INCLUDE A COMPLETE AXIS I-V*
AXIS I: ________________________ AXIS IV: ________________________
________________________ AXIS V: ________________________
AXIS II: ________________________ Diagnosed by: ________________________
AXIS III: ________________________ Date Diagnosed: ________________________
MEDICATION(S): ____
____

PRESENTING COMPLAINT: ____
____
____

HISTORY OF PRESENTING PROBLEM (INCLUDE RECENT ER VISITS OR OTHER CRISIS INTERVENTIONS)
____
____

FAMILY FUNCTION/HISTORY: ____
____
____

Problems with family/Relations? ______ **Custody/Placement?** ________ **Living Situation?** ________________