Keys to Success Family and Developmental Services, LLC
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Initial Referring Screening Form

☐ Outpatient ☐ Intensive In Home ☐ Mental Health Skill Building

☐ Mobile Crisis ☐ Community Stabilization

Name:	
Date of Birth:	Social Security #:
Address:	
Parent/Legal Guardian: ***(if minor)***	
Phone #:	Email:
Insurance Company:	Medicaid #:
Primary Care Physician / Facility:	

Is the individual receiving case management services? ☐ Yes ☐ No **If yes: Explain**

Have you been prescribed a psychotropic medication in the past 12 months? ☐ Yes ☐ No

List below if able:

Does individual have a diagnosis of mental illness?
☐ Yes ☐ No

1.
2.
3.

Was the individual hospitalized for Mental Health
☐ Yes ☐ No

1.
2.
3.

*Please include estimated dates of hospitalization

Reason for Referral:

☐ Aggressive Behavior
☐ Difficulty establishing/maintaining normal relationships
☐ Emotional Problems
☐ Inadequate nutrition
☐ Health or safety is jeopardized
☐ Repeated interventions by the mental health, social service, or judicial System
☐ Unable to recognize personal danger
☐ Unable to recognize inappropriate social behavior
☐ Talks to him/herself
☐ Hears Voices
☐ Major Depression
☐ Paranoid Schizophrenic

Additional Comments:

Disposition FOR OFFICE USE ONLY

Referral admitted into services: ☐ Yes ☐ No If Yes, Date of Admission: _____

Referred to other services for assessment: ☐ Yes ☐ No

Please list other appropriate services identified for referral if not admitted into services:

Name of the Person Obtaining the Information: _____ Date: _____