The Centers, Inc.
Client Contact/Referral Sheet
(Form must be COMPLETELY filled out for appointment to be made)

Select Location for Appointment: ____________________

How Were You Referred to Us? ____________________

Previous Client: ◯ **Yes** ◯ **No** Date: ____________________

☐ ***Child Involved With DCF, KCI, CBC, CRT, Foster Care*** ☐ ***Parent Involved With DCF, KCI, CBC, CRT*** Court Order: ◯ **Yes** ◯ **No**

Name: ____________________ Gender: __________ DOB: __________ SSN: __________

Name of Caller if Not Client: ____________________ Relationship to Client: ____________________

Name of Legal Guardian: ____________________ Relationship to Client: ____________________

Race: __________ Ethnicity: ____________________ Marital Status: __________

Veteran Status: __________ School: ____________________ Grade: __________

Primary Contact Information:

Street Address: ____________________ Apt/Lot/Unit #: __________

City: __________ County: __________ State __________ ZIP Code: __________

Home Phone: __________ Cell Phone: __________ Alternate Contact Phone #: __________

Email Address: ____________________

Reason for Referral or Presenting Problem: ____________________

What Services are you interested in?

☐ Medication Management ☐ Outpatient Counseling ☐ Mental/Behavioral Health ☐ Substance Abuse

☐ Case Management ☐ Co-occurring/Substance Abuse Residential ☐ Parenting/Anger Management

Insurance Information:

Insurance Name: ____________________ **Policy #:** __________ **Group #:** __________

Effective Date: ____________________

Policy Holder Information:

Policy Holder Name: ____________________ **Relationship to Client:** ____________________

DOB: __________ **SSN:** __________ **Gender:** __________

Street Address: ____________________ Apt/Lot/Unit #: __________

City: __________ County: __________ State __________ ZIP Code: __________

Home Phone: __________ Cell Phone: __________

HARD OF HEARING INFORMATION/LANGUAGE INFORMATION

Do you have any hearing loss? ◯ **Yes** ◯ **No** **Primary Language Spoken?** ____________________

Do you need an interpreter? ◯ **Yes** ◯ **No** **Type of Interpreter Needed?** ____________________

Fax Completed Form To: 352-291-5563

TO BE COMPLETED BY INTAKE/REFERRAL SPECIALIST/SCHEDULER

Date Received: __________ Received By: __________

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