



KVC Kentucky Treatment Referral Form
Behavioral Health Services &
Alcohol, Substance Abuse and Co-Occurring Disorders

Client Information

Name: _____ Date: _____
Date of Birth: _____ Social Security #: _____
Phone Number: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP: _____ County: _____
Legal Guardian Name (if different than client): _____
Relationship to Client: _____
Is guardian aware of the referral? Yes No
Gender: Male Female
Ethnicity: African American Asian Caucasian Hispanic Other:
Primary Language: _____ School: _____
The Client's Age Is:
17 Years or Younger _____ 18 Years or Older _____

Insurance Information

Medicaid #: _____
MCO Insurance Provider: _____ MCO Insurance ID #: _____
Primary Insurance Provider: _____ Primary Insurance ID #: _____
Group #: _____ Policy Holder's Name: _____
Secondary Insurance Provider: _____ Secondary Insurance ID #: _____
Group #: _____ Policy Holder's Name: _____

Reason for referral and presenting problems:

Does the client have a previous Behavioral Health Diagnosis? (Examples: Depression, Anxiety, ADHD, Bipolar)

Yes No

If Yes, what is the diagnosis?

Does the client use tobacco, alcohol, or illegal drugs, including prescription medication for non-medical purposes?

Yes No

Does the client hear voices when no one is around, speaking or telling him/her what to do?

Yes No

Does the client have visions, see something or someone, that no one else can see when completely awake?

Yes No

Does the client have current suicidal or homicidal thoughts or behaviors?

Yes No

Within the last 6 months, has the client received in-patient services in a psychiatric hospital, residential treatment facility, substance treatment facility, or crisis stabilization unit?

Yes No

Has the client engaged in violence towards others, made threats of violence, or used weapons against others?

Yes No

Has the client engaged in self harming behaviors in the past month?

Yes No

If younger than 17 years of age, has the client run away from home in the past 3 months?

Yes No

Has the client recently stopped taking or gone without prescribed psychotropic medication?

Yes No

Is the client or their family currently experiencing homelessness, housing or rent problems, unemployment, or difficulty paying bills?

Yes No

Are there any concerns about adult violence in the home?

Yes No

Are there any concerns about adult alcohol use in the home?

Yes No

Are there any concerns about adult illegal drug use, including prescription medication for non-medical purposes, in the home?

Yes No

Has the client been mandated or required to receive treatment (from Court, DCBS, Probation and Parole Officer)?

Yes No

Are there any barriers or concerns about KVC providing behavioral health services in the home?

Yes No

If Yes, what are the concerns about KVC providing services in the home?

D C B S, D J J, or Court Involvement

Is there DCBS involvement? Yes No

Is there DJJ involvement? Yes No

Is there Court or CDW involvement? Yes No

Has there been incarceration in the past 6 months? Yes No

DCBS/DJJ/CDW/Parole Officer Name:

Address:

City: State: ZIP:

Phone: Email Address:

Referral Source Information

Referring Agency:

Referring Agency Contact:

Address:

City: State: ZIP:

Phone: Email:

How did you find out about us?