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 JJ, 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?