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

☐ 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? Has the client had a mobile assessment in the past week?

☐ Yes ☐ No

If yes, what were the treatment recommendations?

Was a higher level of care recommended or discussed?

If a higher level of care was recommended and not referred, what were the symptoms/behaviors of concern at discharge/during the mobile assessment and barriers to the client accessing this level of care?

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

Are there any concerns about adult violence in the home?

☐ Yes ☐ No

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

☐ 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?

Referral Source Information

Referring Agency:

Referring Agency Contact:

Address:

City: State: ZIP:

Phone: Email:

How did you find out about us?