G.P.S.

Gathering Precious Stones, LLC
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Date of Referral: _____

Referring Agency Name: _____

Name & Position: _____

Phone #: _____Email: _____

CLIENT INFORMATION

Name: _____DOB: _____ SSN: _____

Address:_____City:_____State:_____Zip:_____

County: _____ School: _____

Grade Level: _____Race & Gender: _____Current living situation: _____

Parent/Guardian: _____ Relationship to client: _____

Phone #: _____ Cell #: _____ Work: _____

Insurance:

Type of insurance: _____ Insurance number/group number_____

Check if Cash client_ email address:_____

Services Requested	
□ Behavioral Health Evaluation*	□ Family Therapy
□ Psychological Evaluation*	□ Individual Therapy
□ Substance Abuse Services*	□ Skill Building
□ Other Diagnostic Assessment	
Other services needed:	

Reason:

Is the client (Check all that apply)

_____Age 6–18 years old

_____At Risk of out of home placement (hospital, MH residential, etc)?

Has the client (check all that apply)

_____Been identified to have a mental health, DSM-IV, diagnosis?

_____Expressed ideations or attempted suicide or homicide in the past/present?

_____Committed acts of physical or verbal aggression against others?

_____Is client on medications, if so, please list _____

Goals for referral: _____

_____