SERVING THE GREATER AREAS OF BALTIMORE

KING HEALTH SYSTEMS, INC.

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REFERRAL INTAKE FORM

RE: 8/22/14

Date of Referral: **MA #:** **SSN:**

Client Information:

Last Name: ________________________ M.I: ______ First Name: ______________________
Date of Birth: ______________ Age: ____ Sex: _______ Race: __________________
Marital Status: ____________ Occupation: ________________________ Religion: _______________
Address: ______________________________City: _________________ State: _____ Zip code: ________
Telephone #: _________________ Alternate #:_________________
Emergency Contact Name: _________________________________ Relationship: ________________
Address: ___________________________________ City: _______________ State: _____ Zip code: ______
Telephone #:________________ Alternate #:__________________
Parent/Guardian Name: _____________________________________ Relationship: ________________
Address: ______________________________ City: _______________State:_______Zip code: _________
Telephone #: _________________ Alternate #: _________________

English Proficiency: Well ☐ Not Well ☐ Client speak other language: Yes ☐ No ☐ If yes, what language ___________

Deaf: Yes ☐ No ☐ Blind, even glasses: Yes ☐ No ☐ Memory loss: Yes ☐ No ☐

Difficulty dressing/ bathing: Yes ☐ No ☐ Difficulty doing errands: Yes ☐ No ☐ Difficulty climbing stairs: Yes ☐ No ☐

Referral Source:

Name of Person Referring: __________________ Title: ________________ Agency: _________________
Address: ____________________________ __City: _____________ State: ______ Zip code: _________
Telephone #: __________________ Fax #: ___________________

Reason(s) for Referral (Check all that apply):

	Individual Therapy		Couple Therapy		Court Order		Medication Assessment
	Family Therapy		Psycho-Social Evaluation		Psychiatric Evaluation		Medication Management

Brief Description of the Problem: (Behavior, Symptoms, Etc...)

Primary Care Physician: Telephone #: Fax #:

Type of Visit Required: [ ] Home [ ] Office

List All Medications:

For Office Use Only:

EVS Verification:
Type of Insurance: _________________________ Authorization #: ___________________________
Value Options Authorization:

Initial: ____________ Start Date: ______________ End Date: _____________
2 Visits Approved: ________ 150 Visits Approved: ________ Six Month Date Range: ______________________
KHS Representative Signature/Initial: _________________________ Date: ______________________