Colonial Behavioral Health

Child & Adolescent Probation Referral Form

REFERRAL INFORMATION

Referring Person's Name: _____ Date of Referral: _____

Agency/Business: _____ Phone: _____

Reason/Concerns for Referral:

CLIENT'S INFORMATION

Full Name: _____ DOB: _____ Sex: _____

Home Address: _____ City: _____ Zip: _____

Cell Phone: _____

Insurance: ☐ Private/commercial insurance ☐ Public insurance (Medicaid, etc.) ☐ No insurance

PARENT / GUARDIAN CONTACT INFORMATION

Parent/Guardian Name: _____ Relationship: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

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CLIENT'S MEDICAL HISTORY

Current Charges: _____

Substance Use History: _____

History of Positive UDS/ETG on Supervision: _____

Current Substance Use Disorder/Mental Health Providers: _____

_____

History of Mental Health Providers: _____

Fax the referral form, Release of Information, and any supporting documents to Colonial Behavioral Health at 757-253-4018.