



5220 W. Ohio Ave., Lakewood, CO 80226

303-982-6755

## REFERRAL FORM

### Client Information:

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicaid:  Yes  No

Ethnicity: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

### Suggested Services (Please check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Street Smarts      | <input type="checkbox"/> Substance Education  | <input type="checkbox"/> GED Classes                |
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Stress Management    | <input type="checkbox"/> Medication Evaluation      |
| <input type="checkbox"/> Family Therapy     | <input type="checkbox"/> Youth Advisory Board | <input type="checkbox"/> Independent Living Skills  |
| <input type="checkbox"/> Nutrition Class    | <input type="checkbox"/> Housing              | <input type="checkbox"/> Healthy Relationship Class |
| <input type="checkbox"/> Job Assistance     | <input type="checkbox"/> Other: _____         |   |

Please indicate how the above service you have checked off could benefit this youth:

---



---



---



---



---



---

### Referral Source (Person completing this form):

- Friend
- Self
- Parent
- Counselor
- Teacher
- Other: \_\_\_\_\_

**Fax to 303-432-5860 or email to joannes@jcmh.org**