Intensive Family Intervention Service (IFI) Referral

The following items are attached to this referral:
☐ Psychological ☐ Social History ☐Content to Release Information
☐ Committed Information/Commitment Order ☐Insurance Card

Date: _____
Referred By:
☐DFACS ☐DJJ ☐School ☐Parent/Legal Guardian ☐Family Member
☐Community Center ☐Mental Health Facility ☐Substance Abuse Facility
☐Walk-In ☐Telephone ☐Other _____

Name: _____ Agency: _____
Position/Relationship: _____ Phone: _____
Cell/Work: _____ Email: _____

Reason referral was made (i.e. identify the need/issue/problem)?
_____
_____
_____

Youth has (check all that apply):
☐Been identified with a mental health diagnosis/ DSM-IV diagnosis
☐Committed acts of physical or verbal aggression against a parent/guardian, teacher, or peer
☐ Immediate risk of out-of-home placement or is currently in out-of-home placement and reunification is possible

Child: Last Name: _____ First Name: _____
Middle Name: _____ Race: _____
☐**Male** ☐**Female** **Date of Birth: _____** **Age: _____**
Social Security Number: _____
Is child aware of this referral? Y or N

Parent/Legal Guardian: _____ Phone#:_____
Cell #:_____ Work #:_____
Is Parent/Legal Guardian aware of referral? Y or N
Where child can be seen for initial assessment?
Address:
Phone Number:

Insurance: ☐**Georgia Medicaid** ☐ **Peach State/Cenpatico Medicaid** ☐**No Insurance**
Medicaid #:_____ Expiration Date: _____
***How is child's name spelled on Medicaid card? _____**

Fax the Completed Referral Form to 678-731-1552

Official Use Only: Intake Department			
Received	Date:	Time:	By:
Contacted	Spoke to	Date/Time:	
Status	☐ Approved Assessment Date and time		☐Not Approved Reason

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