Maple Star Referral Form

Referring for the following Services:

	Therapy
	PSR/BST
	Adult Day Treatment
	Therapeutic Art Program

Name ____________________ **Medicaid ID** ____________________

DOB ____________________ **Age** ____________ **Male/Female** __________

Legal Guardian ____________________________

Address ____

Phone ______________________ **Other phone** ____________________

Therapist ____________________

Psychiatrist __________________

Referral Contact ________________ **Phone** ______________________

Does the client need an initial **assessment from Maple Star?** ____________________

Strengths: ____

Reason for referral or presenting problems: ______________________________

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If known, please complete the following:

ICD 10: ____________________________

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CASII/LOCUS score: __________

Date completed: __________

Medications/Dosage:

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SED/SMI ____YES _____NO

Previous and Current Treatment: ____
____
____

Clinical Recommendations for Treatment:
Goal 1:____
____
____
Objectives: ____
____
____

Goal 2: ____
____
____
Objectives: ____
____
____

Name of person referring: ________________________________
Name of organization: ___________________________________
Date of referral: _______________

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