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 PO Box 39  
 Sumter, SC 29153  
 Phone (803) 905-5100  
 Referral Fax: (803)905-5171  
 www.sumterbhs.org

## REFERRAL FORM

### Client Information

Name		
DOB		SSN:
Parent/Legal Guardian		
Address		
Phone Numbers		
Insurance	Type:	Ins #:

*(If no insurance, stop by to pick up and complete a Financial Packet prior to first service)*

### Child or Adolescent

**Specify reasons for referral (check all that apply):**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Academic Underachievement<br><input type="checkbox"/> Concerns about sexual health<br><input type="checkbox"/> Destructive behavior/vandalism/stealing<br><input type="checkbox"/> Defiance or aggression towards authority<br><input type="checkbox"/> Disciplinary referrals/suspension<br><input type="checkbox"/> Family concerns<br><input type="checkbox"/> Legal Problems (arrest, probation, DJJ)<br><input type="checkbox"/> Poor peer socialization<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Property destruction<br><input type="checkbox"/> Runaway<br><input type="checkbox"/> School attendance/truancy<br><input type="checkbox"/> Self-harm<br><input type="checkbox"/> Stealing/theft/breaking and entering<br><input type="checkbox"/> Substance Use<br><input type="checkbox"/> Suicide Risk<br><input type="checkbox"/> Verbal abuse/threats/fights |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Adult

**Specify reasons for referral (check all that apply):**

- |                                                                                                                                                                                             |                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Urine Drug Testing<br><input type="checkbox"/> Individual or Family Therapy<br><input type="checkbox"/> Parenting Program<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Substance Use Program<br><input type="checkbox"/> <b>MAT Program</b><br>(For any clients using opioids or heroin) |
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### Referral Information

Referral Date			
Referral Source	<input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Hospital <input type="checkbox"/> DSS <input type="checkbox"/> DJJ <input type="checkbox"/> DOJ <input type="checkbox"/> School <input type="checkbox"/> Other		
If Agency, specify			
Referring Person's	Name:	Title	
	Phone		
	Email:		