SAFETY, TREATMENT, ASSESSMENT and RESOURCES TEAM
SCREENING/REFERRAL FORM

Client Name Date of Referral:

Name of school if applicable: Phone (_____) _____-_____

D.O.B.: Age: Race: Address:

Apt. # City ST ZIP

IF UNDER 18 ONLY:

Has this referral been discussed with the client and/or parent or guardian? ☐ **YES** ☐ **NO**

Is a guardian willing to participate in treatment? ☐ **YES** ☐ **NO**

Parent / Guardian Name:

Relationship to client: **Phone number:**

Is the client currently receiving any other services? ☐ YES ☐ NO ☐ Unknown

If yes, list services/name of provide:

Has provider been notified of this referral: ☐ YES ☐ NO ☐ Unknown

Referral Reasons (please circle all that apply):

☐ Substance Abuse/Use ☐ Suicidal ☐ Homicidal

☐ Untreated Behavioral Concerns ☐ Homelessness ☐ Psychotic

☐ Non-compliance due to Mental Illness ☐ Other barriers due to mental illness

☐ Other: Please share details for reasons of referral. Please include risk factors, safety concerns and reasons this client may have difficulty engaging in traditional treatment:

Referral Source:

Agency: Name of person referring:

Contact Number: Email:

PLEASE FAX or EMAIL Referral TO: FAX : (410)-629-0185 ATTN: Meaghan Kauffman, LCSW-C or BH Clerk
EMAIL: Worcester.referrals@maryland.gov

Questions call (410)629-0164 x 155