START (SAFETY, TREATMENT, ASSESSMENT and RESOURCES TEAM)
SCREENING/REFERRAL FORM

Client Name _____ Client # _____

D.O.B.: _____ Age: _____ Address: _____ ☐ N/A

Contact Name/Client_____ Phone # (_____) _____- _____

Has referral been discussed with client? YES/NO With Parent? YES/NO/ N/A

Is a guardian willing to participate in treatment? YES/ NO/ N/A
If yes, relation to client? _____

Is client currently receiving any services? YES / NO

If yes, list services/name of provider

Has provider been notified of referral? YES/NO

_____ _____

_____ _____

_____ _____

Briefly list reasons for referral. Please include risk factors, safety concerns and reasons this client may have difficulty engaging in traditional treatment_____

_____

_____

_____

_____

_____

Date of Referral: _____

Referral Source:_____

Agency:_____

Contact Number:_____

PLEASE SEND TO: Emily Nichols

FAX : (410) 632-5682 or

MAIL: Snow Hill Health Department
6040 Public Landing Rd
Snow Hill, MD 21863

To be completed by Supervisor

Date referral was received:

_____

☐ Client accepted into program, assigned to:

_____

Date:_____

☐ Client not accepted into program, referred to:

_____

Date:_____

☐ Client/Guardian declined program

Date: _____