Guided Pathways Clinical Solutions, LLC

CLIENT REFERRAL FORM

Client Name:_____ **Date of Referral**:____/____/_____

Date of Birth: ___/____/_____ Age: _____

Where are they located: Detention Center _____(name of facility)

Home /Foster Care_____ Hospital/Other:_____

Attorney's Name: _____

Attorney's Email:_____

Attorney's Phone: Office (____)-_____-_____ Cell (____)-_____-_____

Best way to contact attorney (Please Circle): Office Phone Cell Phone Email

REASON FOR REFERRAL

Please briefly summarize the reasons for a psych eval, the current charges, whether or not the case is CINA or Waiver, etc….: . We will call you for additional detail, so a snapshot is fine.

_____

_____

_____

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_____

COURT INFORMATION

The Court date is scheduled for: ____/_____/_____ at _____:_____ AM / PM

County: _____ District or Circuit : _____

CLIENT CONTACT INFORMATION

Client Phone: (____)-_____-_____ Secondary Phone: (___)-____-_____(parent, spouse, relative)

IF UNDER THE AGE OF 18

Guardian/Caretaker Name: _____

Guardian/Caretaker Primary Phone: (____)-_____-_____ Secondary Phone: (____)-_____-_____

Important - If DJS or DSS is involved in this case please provide the name and contact information of the appropriate case manager:

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Please Fax Completed Form to 443-863-6262

Telephone: 443-453-5045

Email: dreubanks.gpsc@gmail.com