Cruse Medical Care
Empowering Individuals and Families

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Referral Form

CMC ONE STOP SHOPPING BEHAVIORAL HEALTHCARE CENTER

Referring Agency: _____ Referral Date: _____ Time_____
Referred by:Mr/Ms/Mrs _____ Phone of Ref. Individual: (____) ____-_____

1. Referral Sources:

☐ DFCS	☐ Other Physician	☐ Community Agency	☐ Adoption agency
☐ Health Department/ Hospital	☐ Juvenile/ Family Court	☐ School	☐ Family Member
☐ DJJ	☐ Law Enforcement	☐ Group Home/Shelter	☐ Other_____

2. List Requested Services:

CMC Comprehensive Services (Ages 3-17)
☐ Psychiatric Evaluation ☐ Medication Management ☐ Psychological Evaluation/Testing
☐ Individual/Group Therapy ☐ Family Therapy ☐ Anger Management ☐ Other: _____
☐ In-House/School/skills building (CSI Services) ☐ In-Home Parenting Education/Skills

Dr. Shelly Yusuff, MD
☐ Psychiatric Evaluation (Adult/Child) ☐ Medication Management
☐ Individual therapy ☐ Group therapy ☐ Family Therapy

3. Reasons for Referral: (Check all that apply)

☐Child Abuse	☐Anger Management	☐Run Away Behavior	☐Reunification Plan	☐Academic Support/ Truancy	☐Teen Pregnancy
☐Child Neglect	☐Placement Support	☐Substance Abuse	☐Family Therapy	☐Juvenile Delinquency	☐Gang Involvement
☐Sexual Abuse	☐Life Skills Training	☐Crisis Intervention	☐Individual Therapy	☐Behavioral Management	☐Other: _____

4. Can you tell me a little about the patient and his/ her situation? (Explain)_____
_____

5. Family/ Placement Information: Name of Parent/ Guardian: _____

1. Is patient in a Group Home? Yes/ No
2. Is patient currently seeing another Doctor? Yes/ No
3. Is patient currently seeing a therapist? Yes/ no
4. Is patient currently with another agency? Yes/ No

6. Contact Information:

Home #: (__) ____- Work # : (__) ____- Cell #: (__) ____-_____
Address: _____
City: _____ State: _____ Zip Code: _____

7. **Consumer Information**:

Patient Name: _____ DOB: _____ SS#_____
School/ Grade: _____
Medical Plan: ☐ Medicaid ☐ Amerigroup ☐ Peach State ☐ None ☐ Other: _____
Has the consumer been diagnosed or has suspected mental retardation or autism: Yes/ No
(Please attach Psychological/ Psychiatric Assessment)
Medicaid#_____ is consumer involved in a community MH Program? Yes/ No

Please check all that apply:

☐ADHD	☐Learning Disability	☐Depression
☐Conduct Disorder	☐Mental Retardation	☐Substance Abuse/ Dependency
☐Oppositional Disorder	☐Bipolar/ Manic Disorder	☐Schizophrenia or other Psychotic Disorder
	☐Other: _____	