REFERRAL FORM

Please fill out this form and either bring it, e-mail it, mail it or fax it

Clinic where you prefer to receive services (please check):

☐ **Calvert** 55 Stoakley Rd. Suite 7 (2nd floor) Prince Frederick, MD 20678 **Phone:** 240-296-6066 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org	☐ **Lexington Park** 46940 S Shangri La Dr Suite 15, Lexington Park, MD 20653 **Phone:** 240-296-6050 **Fax**: 301-263-7304 **Email:** IRCSoMD@Vesta.org
☐ **Forestville** 3900 Forestville Road Forestville, MD 20747 **Phone:**240-296-6066 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org	☐ **Odenton** 1202 Annapolis Road, Suite F Odenton, MD 21113 **Phone:** 443-396-3110 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org
☐ **Germantown** 20410 Observation Dr. Suite 108, Germantown, MD 20876 **Phone:** 240-296-5858 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org	☐ **Silver Spring** 8737 Colesville Rd. Suite 700, Silver Spring, MD 20910 **Phone:** 240-296-5858 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org
☐ **Lanham** 9301 Annapolis Rd Lanham, MD 20706 **Phone:** 240-296-6323 **Fax:** 240-383-3435 **Email**: IRC@Vesta.org	☐ **Waldorf** 22 Industrial Park Drive Suite A, Waldorf MD 20602 **Phone:** 240-296-6050 **Fax**: 301-263-7304 **Email:** IRCSoMD@Vesta.org

*Intakes in **Germantown** are walk- in on Tuesdays from 10am to 1:00pm and 1:30pm to 4:30pm ONLY*
*Intakes in **Silver Spring** are walk- in on Wednesdays from 10am to 1:00pm and 1:30pm to 4:30pm ONLY*

Referral Source Information

Self ☐ Date: _____
Referral Source (Name):_____ Agency: _____
Address:_____ City: _____
County: _____ State: ____ Zip Code: _____ Phone: _____ Fax: _____

Client Information

Marital Status_____ Race/Ethnicity_____ Gender: M ☐ F ☐
Client's Name: _____ DOB: _____ SSN:_____
Address: _____ Email Address: _____
City: _____ County: _____ State: ___ Zip Code: _____ Phone: _____ Cell Phone: _____
Native Language (If other than English): _____ Does Client Speak English? Yes ☐ No ☐
Caretaker Name or Emergency Contact: _____ Daytime Phone: _____
Relationship to client: Parent ☐ / Foster parent ☐ / Legal guardian ☐ / Social Worker ☐ / Case Manager ☐ / Other _____
Does Caretaker Speak English? Yes ☐ No ☐

Reason(s) for Referral (check all that apply)			
☐ Therapy/Counseling	☐ Medication assessment	☐ Court ordered	☐ Report needed
☐ Psychiatric evaluation	☐ Diagnosis evaluation	☐ Testimony required	☐ Next hearing date (if known)
☐ PRP (Germantown, Odenton, Lanham and Forestville offices ONLY)			☐ Discharged from inpatient facility
☐ Supported Housing (Germantown, Odenton and Lanham offices ONLY)			☐ Other_____

Payment Information: ☐ Medicaid ☐ Medicare ☐ Medicaid/Medicare ☐ Private Insurance ☐ Self Pay

Medicaid#: _____ Medicare#: _____
Name of Private Insurance: _____ Person Insured (Subscriber): _____
Client's ID: _____ Group#:_____

Brief Description of Problem. (Use a separate sheet if necessary).
Please forward relevant medical & behavioral information, court orders, reports from previous evaluations, social summaries, if discharge from inpatient facility-attach copy of after care plan and discharge summary, etc.

Therapy Session-Time Availability (check all that apply)	9:00 - 12:00	12:00 - 5:00	5:00 - 8:00
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Current Diagnosis Information: _____
_____
Current medications: _____
_____
Do you require ADA (American with Disabilities Act of 1990) accommodations? If yes, explain: _____
_____

VESTA ONLY

Staff receiving this referral: _____ Comments: _____