ELEVATE HEALTHCARE

Referral & Consent

Free Mental Health Screenings | Statewide
Email Referrals To: info@elevatehealthcare.us
Call: 214-271-9962 | Fax: 214-964-0817

CLIENT INFORMATION ☐ Child (5-12 yrs) ☐ Adolescent (13-17yrs)

Client Name: _____ Date of Birth: _____

Parent/Guardian (If Applicable): _____ Phone#: _____

Address: _____ City _____ State: _____ Zip: _____

Insurance Provider: _____Subscribers Name: _____

Member ID / Group ID: _____

Language Spoken ☐ English ☐ Spanish Email: _____

Recommendations for the Following Service (s) ☐ **Free Mental Health Screening**
☐ Initial Assessment ☐ Partial Hospitalization ☐ Intensive Outpatient Programming
Group programming includes Individual Therapy, Family Therapy, and Medication Management part of programming.
Diagnosis/Concerns:_____

CONSENT ****** PLEASE COMPLETE THIS SECTION******

Client's Release of Information: I authorize referral source to communicate with Elevate Healthcare for the purpose of tele screening, communication, and scheduling my appointment. A authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicated with referring physician or referral source.
Client Signature: _____ Date: _____
☐ Please check box if client provided verbal consent.

Referral Source Information ☐ ISD ☐ Court ☐ Provider

Person Making Referral: _____

Referral Organization: _____Phone#_____

Office Contact Person: _____ Fax# _____

Email: _____

ELEVATE HEALTHCARE USE ONLY

Appointment Scheduled: Date: _____ Time: _____

Client Unable / Declined to schedule: Reason: _____

Note: _____

Elevate Healthcare team member completing this document: _____