Pathways
Transition Programs, Inc.
120 East Trinity Place • Decatur, GA 30030 Phone (404) 378-2300 • Fax (404) 378-2394

REFERRAL FORM

If other than self-referral or caregiver referral

REFERRAL SOURCE			Date:
Name:	Agency		Title:
Phone #:	Fax #:	E-mail:	

CLIENT INFORMATION *(Confirm correct name spelling and DOB with client and/or guardian.)*			☐ Male ☐ Female
First Name:	Last Name:		DOB:
Social Security #:	Insurance Name and Number:		
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	
Name of School:			

If the client is a minor, please complete the following

CAREGIVER #1		Relationship to Minor:	
First Name:	Last Name:		DOB:
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	
CAREGIVER #2		Relationship to Minor:	
First Name:	Last Name:		DOB:
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	

How did you hear about us?	☐ Online Search ☐ Email from us ☐ Colleague ☐ Friend ☐ Social, please specify:

Do the caregivers have full custodial rights to make medical and educational decisions for this child?	☐ Yes	☐ No
Is there another parent or caregiver with joint custody we should inform about treatment?	☐ Yes	☐ No
Does the client have thoughts of self-harm or of harming others?	☐ Yes	☐ No
Does the client have an urgent or critical medical condition?	☐ Yes	☐ No
Does the client have a safety threat?	☐ Yes	☐ No

REASON FOR REFERRAL? OTHER COMMENTS?
Requested Services: ☐ Counseling ☐ Medication Management ☐ Diagnostic/Assessment ☐ Group

*****Please note: medication management (psychiatric) services are only available for clients receiving counseling services. We are unable to accept referrals for medication management only.***