TRIAD Health Systems Inc.

Referral for Counseling Services

Is the client seeking medication management services □Yes □No
Are you currently involved in counseling services with a different agency (if so please provide name of agency)
_____

Client's Name: _____ **Gender:** □Male □Female

Date of Birth: _____ **Age:**_____

Guardian's Name: (if applicable)
_____

Client Address:
_____City:_____

State: _____ Zip: _____Phone #: (____) _____

Client's Social Security Number: _____

Method of Payment: □ KY Medicaid □ Other Insurance □ Self-Pay/Sliding Scale
Managed Care Organization/Insurance Carrier: _____

Insurance Group # or KY Medicaid #: _____

Primary Diagnosis (if known): _____

Other services involved in the home: _____
Current Concerns/Reason Seeking Treatment: _____
_____
_____
_____

Are there any current safety concerns at this time? □Yes □No (if yes, please refer to emergency room and note below): _____
_____
_____

Referral Source Name, Address and Phone Number:
_____
_____

How did you hear about us? _____

P.O. Box 845 ♦ Warsaw, KY 41095

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Fax: 859-567-1253