



Thrive Referral Form

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Thrive strives to acknowledge receipt of referrals within 3 business days. Please contact the office if not contacted within that time. Black ink only.

Returning Client: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Female <input type="checkbox"/> Male		Date:	
Client Name:				Date of Birth:	
SS#:			MA #		
Address:		Apt. #:	City:		Zip Code:
*Social Security # must be known to complete intake					
Adult Client or Parent/Guardian:			Referral Source:		
Name:			Name:		
Guardian Relationship:			Relationship:		
Home:			Agency/School:		
Mobile:			Email:		
<input type="checkbox"/> Home <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Foster Care <input type="checkbox"/> Homeless			Office:		Mobile:
Screening Questions: <u>If you answer yes to any of the following, please call our office to speak to an intake coordinator or supervisor prior to sending referral.</u>					
1. Do you/your child/client have any thoughts or plan to harm or kill yourself/themselves?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
2. Do you your child/client have any thoughts or plan to harm or kill anyone else?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
3. Do you your child/client have any type of hallucinations?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
4. Is there domestic violence in the home?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
5. Is there a sexual offender residing in the home?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
6. Are you/your child/client violent towards others?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
If an emergency or urgent crises arises, call 911 or a crisis number such as Baltimore Crisis Response at 410-931-2214.					
Please answer the following questions:					
Is the consumer of Hispanic, Latino, or Spanish origin?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unavailable		
Race:			<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Not Available		
How well does the consumer speak English?			<input type="checkbox"/> Well <input type="checkbox"/> Not so well <input type="checkbox"/> Not at All		
Does the consumer speak another language other than English at home?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what is the language?			<input type="checkbox"/> Spanish <input type="checkbox"/> Other		
Number of Arrests in the Past 30 days?			<input type="checkbox"/> None <input type="checkbox"/> 1-99		
Is the consumer deaf or do they have hearing difficulty?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Reason for Referral: Please give detailed description of symptoms/problems that are the reason for referral such as depression, anxiety, anger management, and mood lability. Please note any history of suicidal or homicidal ideation, aggression, self-harm, and/or hallucinations. Hospital referrals require discharge paperwork. DSS/DJS must complete intake paperwork and provide guardianship paperwork in order to process referrals if guardian will not be at intake.

Internal Use Only-- M #:	EMR#:	Effective Date:	S/O#:
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