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& Return To: intake@premiercsga.com

PREMIER COMPREHENSIVE SERVICES, LLC

2001 Martin Luther King Jr. Dr. SW
Suite 410C
Atlanta, GA 30310

Referral Form

CLIENT INFORMATION	
Date:	
Name:	
Date of Birth:	
Social Security Number:	
Race/Ethnicity:	
Parent/ Guardian Name:	
Address: (Current Placement)	
City/State/Zip:	
Home Phone Number:	
Cellular Phone Number/Alt #:	
DFCS Worker/PO:	
Phone Numbers (Office/Fax/Cell /Email):	
School/Grade/Employer:	

INSURANCE INFORMATION	
Insurance:	☐**No** ☐**Yes, Provider's Name:**
Medicaid:	☐ **Amerigroup** ☐ **CareSource** ☐ **Peach State** ☐ **SSI/Medicaid** ☐ **Other:** ☐ **N/A**
Insurance Number:	

REASON FOR REFERRAL			
Presenting Problems: (Include: Mental/Behavioral health history, Substance Use, Medical Concerns,)			
DIAGNOISIS: (Current, History)			
Medication: (medical/psychiatric)			
Services Requested: **Check all that Apply* **Location Request:** ☐In-Home ☐In-Office ☐Virtual	☐ **Individual Counseling**	☐ **Group Counseling/Training**	☐ **Family Counseling / Training**
	☐ **Assessments / Evaluations** ***Family, Substance, Anger, etc.***	☐ **Family Violence Intervention**	☐ **Trauma Focus – Cognitive Behavior Therapy**
	☐ **Behavior Health Assessments and Service Plan Development**	☐ **Psychiatric Evaluation**	☐ **Parent Education Class** ☐ **Fatherhood Education Class**
	☐ **Community Support (CSI)**	☐ **Family Preservation**	☐ **Brief Crisis Stabilization**
	☐ **Psychological Evaluation**	☐ **Anger Management**	☐ **Substance Abuse Treatment** ☐ **Substance Abuse Education**

******** OFFICE USE ONLY *********

Appointment Scheduled: ☐ **No** ☐ **Yes** **Location:**

Assessor: _____ **Appointment Date:** _____ **Appointment Time:** _____