REFERAL FORM				
Child's Name:			Insurance Name:	Insurance ID:
Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female	Age:	Race:
Home Address: ______________________________ City: _________________ State: ________________Zip Code: ______________			Email:	
Guardian's name: ___________________________ Primary language spoken at home: _____________ Phone Number:____________________________			PCP: _______________________________ Phone Number: ______________________________	

REFERRAL SOURCE	
Date of Referral: ____________________________	
Client Referred by: ___________________________	Phone: __________________________

EMERGENCY CONTACTS *(if provided by parent)*	
Name:	Relationship to recipient:
	Telephone number(s):

EDUCATION	
Name of School/Daycare/Group Home:	Telephone #:
DSM-5 Code and Description:	Reason for the Admission:
(Office use only) Eligibility Ck by: _______________________ Client #: _______________________	*(Office use only)* Date Received: ______________________ Received Via: __ Fax __Walk in __Phone

P: (561)506-3665 F: (561)444-2458	1521 Forest Hill Blvd, Suite 3B, Lake Clarke Shores, FL, 33406 rainbowoflifebhcadmissions@gmail.com	***Please complete the form and Fax or Email***