IMPACTING *tomorrow* HEALTH CENTER

"Improving The Quality of Lives"

Vocational Program Referral Form

Demographic Information

Client Name:		DOB:	Age:
Address:		City:	Zip:
Contact Number:	SSN:	Medical Assistance #:	
Gender:	Ethnicity:	Marital Status:	
Highest Completed Grade Level:	Employment Status:	Legal Status (# of arrests in past 30 days):	
Legal Guardian Name (if applicable):	Relationship:	Email Address:	

Reason For Referral (check all that apply):

☐ Behavior/Conduct ☐ Emotional Mental Illness ☐ Employment Instability
☐ Legal/Probation/Court Mandated ☐ Social/Interpersonal Challenges ☐ At Risk
☐ Substance Use/Abuse ☐ Educational Instability

Services Requested (check all that apply):

☐ Vocational Training ☐ Supported Employment ☐ Life Skills Training ☐ Entitlement Needs ☐ Crisis Intervention ☐ Recovery and Relapse Understanding ☐ Increase Social Supports ☐ Social Interpersonal Skills Training ☐ Social/Interpersonal Skills Group Counseling ☐ Promotion of Wellness & Self-Management

Please Indicate Current Diagnosis (If Applicable and Known):

Primary Behavioral Diagnosis (DSM-V):	Description:
Diagnosis Given By:	Date:

Social Elements Impacting Diagnosis

☐ None ☐ Educational ☐ Financial ☐ Access to Health Care ☐ Legal System/Crime ☐ Primary Support(s)
☐ Housing Problems ☐ Occupational ☐ Other Psychosocial/Environment ☐ Social Environment
☐ Homelessness ☐ Unknown/Other

Please List ALL Medications:

Is the client compliant with their medication(s): ☐ Yes ☐ No

Please discuss the presenting symptoms and the frequency/duration:

Referring Mental Health Professional:	Contact Number:	Email Address:

Referring Mental Health Professional Signature & Credentials **Date**

Treating Psychiatrist:	Credentials:	Email Address:
DORS Counselor:	Contact Number:	Email Address:

Please submit completed referral via email to referral@ithc.co or fax to 443-451-8344 to Impacting Tomorrow Health Center, Co. Please include a copy of client's diagnostic evaluation and any other supporting documentation when completing the referral.

Impacting Tomorrow Health Center Administrative Use Only

Check off once completed	Date Completed
☐ Verify Eligibility	
☐ Contact referral source and client	
☐ Scheduled Orientation and Intake Meeting	**Date of meeting:**

_____ _____

Administrative Coordinator Printed Name Signature & Date