AGS PROGRAMS, LLC

"Achieving Your Greatest Self"

Referral for Services

Returning Consumer: ☐ **Yes** ☐ **No** **Date:** _____

Consumer Name:	Date of Birth:
SS#:	MA#:
Gender:	Phone Number:
School/Grade (if applicable):	Address:
Consumer Availability:	Preferred Location of Services:

SOCIAL SECURITY NUMBER MUST BE KNOWN TO PROCESS REFERRAL

Referral Source Information

Name:	Agency (if applicable):
Phone Number:	Email Address:

Parent/Guardian Information:

Name of Parent/Guardian:	Relationship:
Address:	Contact Number:

A LEGAL DOCUMENT MUST BE PRESENTED TO SHOW GUARDIANSHIP

Please answer the following:

Is the consumer of Hispanic, Latino, or Spanish origin?	☐ Yes ☐ No ☐ Unavailable
Race:	☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Not Available
How well does the consumer speak English?	☐ Well ☐ Not so well ☐ Not at all
Does the consumer speak another language other than English at home?	☐ Yes ☐ No
If Yes, what is the language?	☐ Spanish ☐ Other
Number of arrests in the past 30 days?	☐ None ☐ 1-99
Is the consumer deaf or do they have hearing difficulty?	☒ Yes ☐ No ☐ Unknown
Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses?	☐ Yes ☐ No ☐ Unknown

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REASON FOR REFERRAL: In your own words, describe the child/adult in need for therapy services. Please describe any behaviors the child/adult is exhibiting. Please specifically note any of the following whether current of a history of: Recent Hospitalizations, Suicide Attempts or Ideation, Self-harm, Violence towards others, Aggression, Domestic Violence, Psychotic Symptoms, Substance Abuse, Behavior Problems, & Mood Related Symptoms.

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