laurel house
resources to recover

Laurel House, Inc. Referral Form

For More Information, Contact:
Daryl Mohammed, Client Intake/
Provider Outreach Counselor
(P): 203-487-1619

Today's Date _____

PROGRAMS AND SERVICES OF INTEREST

☐ Thinking Well (Cognitive Remediation) ☐ Supported Employment ☐ Supported Education ☐ Skill Building Workshops

Client Name _____ S.S. # ___ - ___ - ____ D.O. B. _____ Gender: _____
Address _____ City _____ Zip _____
Cell Phone #: _____ E-mail _____ Race/Ethnicity _____
Marital Status _____ Medical Ins. _____ ID # _____ Religion _____
Primary Language _____
Highest Grade Completed: _____ Currently in School? **Y / N** Employed? **Y / N**
Legal History **Y / N** *if yes, please explain:* _____

DSM-5 Psychiatric Diagnosis *Please provide DSM code and description*

DSM-5 (F-code) Dx		
Secondary Dx		

Current Medications:

Name	Amount/Frequency	Prescriber

Substance Use History: _____

_____

Reason for Referral: _____

_____

_____

_____

_____

_____

Referrer Information:
Name: _____ Phone: _____
Agency: _____ Email: _____
Address: _____ Fax: _____
Therapist (if different from referrer): _____ Phone: _____
Psychiatrist (if different from referrer): _____ Phone: _____

Signature of Referrer: _____

Please fax or email completed Referral Form to dmohammed@laurelhouse.net , or fax: (203) 969-7021