CETPA
Mental Health & Substance Abuse Services
Servicios de Salud Mental y Abuso de Sustancias

Referral Form

Please fill out the following form and send it to referrals@cetpa.org or 770-449-5023

Date: Click here to enter a date.

Types of Services Needed

Program: Choose an item.

Services: (choose all that apply)

- ☐ Substance Abuse Evaluation
- ☐ Psychiatric Evaluation
- ☐ Family Counseling
- ☐ Psychiatric Medication
- ☐ Tele-Counseling
- ☐ Mental Health Evaluation
- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Apex (School Based Counseling)
- ☐ Other _____

Presenting Problems: (choose all that apply)

- ☐ Suicidal/Self Injury
- ☐ Substance use/ abuse
- ☐ Physical Agression/Homicidal ideation
- ☐ Sexual Acting Out
- ☐ Fire/Setting / Property destruction
- ☐ Psychosis

General Information

Name: Click here to enter text. Click here to enter text. **Age**

First Name Last Name

Gender: Choose an item. **Date of Birth** Click here to enter a date. **Home Phone:**

Cellular Phone: **County:** Click here to enter text. **Client lives with:** Click here to enter text.

Street Address: Click here to enter text. **Street Address Line 2:** Click here to enter text.

City: Click here to enter text. **State** Click here to enter text. **Zip Code**

If under 18 years old

Parent / Legal Guardian 1: Click here to enter text. Click here to enter text.
First Name Last Name

Phone Number:

Street Address: Click here to enter text. **Street Address Line 2:** Click here to enter text.

City: Click here to enter text. **State** Click here to enter text. **Zip Code**

Parent / Legal Guardian 2: Click here to enter text. Click here to enter text.
First Name Last Name

Phone Number:

Street Address: Click here to enter text. **Street Address Line 2:** Click here to enter text.

City: Click here to enter text. **State** Click here to enter text. **Zip Code**

Medical Information

Medical Coverage (Choose all that apply)

☐ Medicaid ☐ PeachCare ☐ Unknown
☐ Private Insurance ☐ CMO Medicaid ☐ None

If CMO, Care Management Organization: Medicaid or PeachCare #:

List known medications:

Prescribing Physician:

Legal Problems

Legal Involvement:
☐ DFCS ☐ Adult Probation ☐ Adult Criminal Court
☐ Probate Court ☐ Treatment Court ☐ Jail / Law Enforcement
☐ Juvenile Justice ☐ Parole

Charges: **Number of arrests in the last 30 days:**

Probation Officer's Name: Click here to enter text. Click here to enter text.
First Name Last Name

Probation Officer's Phone Number:

Referral Information

Referral Name: Click here to enter text. Click here to enter text.
First Name Last Name
Referral Organization: Click here to enter text.

Phone: **Fax:**

Reason for Referral / Comments: Click here to enter text.

Send referral to referrals@cetpa.org or by fax to 770-449-5023.