Improving Outcomes, LLC

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Screening and Referral Form

Date of initial contact: _____ Referred by: _____

Method of Screening: _____ Phone Number: _____

Name: _____ DOB/Age: _____ Gender: _____

Parent Name: _____

Address: _____

_____

Phone number: _____ Funding Type: _____

Medicaid #: _____

Service Requested:

Presenting problem (what's happening right now):

History of medical care, including current medical problems, psychiatric problems, and medication history and current use:

Screening recommendation:

Disposition of screening and referral:

_____ _____

Name and Credential of Screener Date