Balanced Minds, LLC

Pre-Screening Form

Date of Referral: _____

Indentifying Information: **Method of Screening:** ❑ Telephone ❑ Written ❑ Face to Face

Name: _____ Date of Birth: ___/___/_____ Race: _____

Gender: ❑ Female ❑ Male SSN#: ___-___-_____ Medicaid #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (___)_____ Email: _____

Parent/Authorized Representative Name: _____ Phone: (___)_____

Address: _____ City: _____ State: _____ ZIP: _____

Referral Source Name: _____ Referral Source Agency: _____

Referral Telephone: (___)_____ Referral Fax: (___)_____

Referral Address: _____ City: _____ State: _____ ZIP: _____

Current Problems: (please describe the individual's needs which require mental health services)

Psychiatric:

Medical (include current medications and history of medical care)

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Medical Problems:

Risk of Falls: ○ **Yes** ○ **No** **If yes, please explain:**

Communication Barriers: _____

Administration Use Only

Screening Recommendation and Disposition Plan:

☐ Based on the above information and information obtained, applicant is appropriate for the program and will be Admitted.

○ If applicant is appropriate for services, the assessment is scheduled for:

Date: _____ Time: _____

☐ Based on the above information and information obtained, applicant is **not appropriate** for services and will be recommended for appropriate services. Recommendations are:

Counselor Signature: _____ Date: _____