



# REFERRAL FORM

Family Guidance of Texas Inc.  
Children, teens, adults & families

## SUBMIT COMPLETED FORM TO:

Phone: 713-485-4505

Fax: 346-502-6729

Email: [information@fgotx.org](mailto:information@fgotx.org)

Use secure/encrypted email for client details.

Please complete this form and send it with any available history or physical information. We will arrange an intake interview and determine eligibility for services. Questions? Call us — we're glad to help.

## CLIENT INFORMATION

|                      |                      |                           |                      |                      |                      |
|----------------------|----------------------|---------------------------|----------------------|----------------------|----------------------|
| Date of referral     | <input type="text"/> | Referred by (name)        | <input type="text"/> |                      |                      |
| Client name          | <input type="text"/> | DOB                       | <input type="text"/> | Age                  | <input type="text"/> |
| Gender               | <input type="text"/> | Race/ethnicity (optional) | <input type="text"/> | Preferred language   | <input type="text"/> |
| Address              | <input type="text"/> |                           |                      | City/State/ZIP       | <input type="text"/> |
| Phone                | <input type="text"/> | Alternate #               | <input type="text"/> | Email                | <input type="text"/> |
| Parent/guardian name | <input type="text"/> |                           | School / employer    | <input type="text"/> |                      |
| Medicaid #           | <input type="text"/> | Insurance ID #            | <input type="text"/> | SS #                 | <input type="text"/> |

## INSURANCE PROVIDER — PLEASE ATTACH A COPY OF THE INSURANCE CARD

|                                                           |                                                            |                                                       |
|-----------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Molina                           | <input type="checkbox"/> Texas Children's Health Plan STAR | <input type="checkbox"/> Community Health Choice STAR |
| <input type="checkbox"/> UnitedHealthcare STAR            | <input type="checkbox"/> Superior                          | <input type="checkbox"/> Wellpoint                    |
| <input type="checkbox"/> Ambetter — Core Plan             | <input type="checkbox"/> Ambetter — Premier Plan           | <input type="checkbox"/> Traditional Medicaid         |
| <input type="checkbox"/> Single Pregnant Woman (Medicaid) | <input type="checkbox"/> Medicare                          | <input type="checkbox"/> Uninsured / not sure         |
| Other plan                                                | <input type="text"/>                                       |                                                       |

Uninsured? Send the form anyway — our team will discuss options.

## PREFERRED SERVICE LOCATION

|                                              |                                          |                                                          |
|----------------------------------------------|------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Houston — Southwest | <input type="checkbox"/> Houston — North | <input type="checkbox"/> Texas City                      |
| <input type="checkbox"/> Crockett            | <input type="checkbox"/> Tyler           | <input type="checkbox"/> In-home / telehealth / not sure |

## PRESENTING ISSUE(S)

## CARE TEAM & REFERRAL SOURCE

|                        |                      |                              |                      |
|------------------------|----------------------|------------------------------|----------------------|
| Primary care physician | <input type="text"/> | PCP phone #                  | <input type="text"/> |
| Referral source        | <input type="text"/> | Provider / agency / facility | <input type="text"/> |
| Referrer phone         | <input type="text"/> | Referrer email               | <input type="text"/> |



## Referral Form — page 2

Client name:

Date:

### ADDITIONAL QUESTIONS

Date of last hospitalization (if any)  How many children in the household?

Currently enrolled with another mental health provider? ☐ Yes ☐ No If yes — facility & last date seen

Currently taking medication for mental health? ☐ Yes ☐ No If yes — list medications

### CONCERNS OBSERVED — CHECK ALL THAT APPLY

- |                                                                  |                                                            |                                                    |
|------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Anxiety                                 | <input type="checkbox"/> Obsessions/compulsions            | <input type="checkbox"/> Withdrawal/isolation      |
| <input type="checkbox"/> Criminal behavior (stealing, vandalism) | <input type="checkbox"/> Insomnia or hypersomnia           | <input type="checkbox"/> Excessive energy          |
| <input type="checkbox"/> Constant restlessness                   | <input type="checkbox"/> ▲ <b>Obsession with firearms</b>  | <input type="checkbox"/> Impulsiveness             |
| <input type="checkbox"/> Low self-esteem                         | <input type="checkbox"/> Fidgety                           | <input type="checkbox"/> Crying spells             |
| <input type="checkbox"/> Violent/aggressive behaviors            | <input type="checkbox"/> Fighting                          | <input type="checkbox"/> ▲ <b>Gravely impaired</b> |
| <input type="checkbox"/> Forgetfulness                           | <input type="checkbox"/> ▲ <b>Fire-setting</b>             | <input type="checkbox"/> Running away              |
| <input type="checkbox"/> Defiance/oppositional                   | <input type="checkbox"/> Lying                             | <input type="checkbox"/> Phobias                   |
| <input type="checkbox"/> Destructiveness (destroying property)   | <input type="checkbox"/> ▲ <b>Cutting self</b>             | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> ▲ <b>Hurting animals (pets)</b>         | <input type="checkbox"/> Disrespectfulness                 | <input type="checkbox"/> Bullying                  |
| <input type="checkbox"/> Change in appetite                      | <input type="checkbox"/> ▲ <b>Self-injurious behaviors</b> | <input type="checkbox"/> Hyperactive               |
| <input type="checkbox"/> Hallucinations (visual, auditory, etc.) | <input type="checkbox"/> Difficulty concentrating          | <input type="checkbox"/> ▲ <b>Homicidal</b>        |
| <input type="checkbox"/> Excessive talking                       | <input type="checkbox"/> Temper tantrums                   | <input type="checkbox"/> ▲ <b>Suicidal</b>         |

▲ **Safety-critical** — if any are checked, complete the safety triage section below before submitting.

#### SAFETY TRIAGE — URGENT OR CRITICAL NEEDS

If the individual presents as suicidal, homicidal, or gravely impaired — or with any urgent or critical need — contact a licensed clinician immediately for further assessment and triage. Document the clinical disposition below. In an emergency, call 911.

Licensed clinician consulted  Date/time

Clinical disposition / notes

#### FOR OFFICE USE ONLY

Received by  Date received  Insurance verified? ☐ Y ☐ N

Assessment date  Psych evaluation date