MEDALLION HEALTH CARE SERVICES, LLC.
REFERRAL FORM

Type of Service Requested: ☐ **One-Time Consultation** ☐ **Ongoing Mental Health Targeted Case Management Services**

Person Making Referral: ______________________ Telephone #: ____________

Address: ______________________ Fax #: ____________

Last Name: __________ First Name: __________ M.I.: ____ Sex: ____ DOB: ______

Address: __________ City: __________ State: ______ SS#: ______

Zip Code: ______ Telephone: ________ Other: ________

Primary Language: __________ Race: ________ Ethnicity: ________

Parent/Guardian/Other : ______________ Daytime Phone #: ________

Address: ______________________ Primary Language: ________

Person/Parent/Guardian agrees to referral: ☐ Yes ☐ No OK to telephone person/parent/guardian: ☐ Yes ☐ No

Brief history & chief complaint/ presenting problem: ______________________

Check all that apply:

☐ Alcohol Use/Drug Abuse/Dependence ☐ Anger, Aggressive, Defiant Behavior ☐ Difficulty following directions

☐ Pregnant ☐ Antisocial/ Conduct Disorder ☐ ESE (Special Ed)

☐ Depression ☐ Obsessive/ Compulsive ☐ Mood swings

Other Explain:

For Office Use: Date of Receipt: ______________ ☐ Crisis ☐ Urgent ☐ Routine

☐ Referred to: ______________ Appointment Scheduled: ☐ Yes ☐ No Date/Time: ________

☐ Waiting List: ☐ Not Referred for Mental Health Services (specify reason): ______________

Person Notified: ________ Date of Notification: ______ Person Notified: ________

Medallion Health Care Services LLC.
847 Orange Ave., Suite B, Daytona Beach, FL 32114
Phone: 386-341-0550, Fax: 386- 675-6592
or
Jacksonville:
9951 Atlantic Blvd., Suite 163, Jacksonville, FL 32225
Phone: 904-371-2800, Fax: 904-725-0423