REFERRAL FORM – Mending Point

Referring Source:

Name: ______________________________ Affiliation: ______________________________

Phone #: ____________________________ Email: ___________________________________

What is the best way for us to follow up on this referral?

☐ Contact referring source directly ☐ Contact person/family being referred directly

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Client Information:

Name:________________________________Age/DOB:______________________SSN: ___________________

Parent/Guardian's Name (for persons under age 18):____

Address: ____

County: _________________Phone#: __________________ Alternate Phone#: _________________________

School attending (if applicable): ____________________________ Grade Level: _________________________

IEP/504 Plan: ☐ Yes ☐No **Primary Language Spoken in Home**: ______________________________

Is treatment court ordered? ☐ Yes ☐No

Any substances being used or suspected of being used:

Current Charges (if applicable):

Please indicate source of payment for services: ☐ Anthem (Medicaid) ☐ Aetna (Medicaid)
☐ Humana (Medicaid) ☐ Passport (Medicaid) ☐ Wellcare (Medicaid) ☐ Private insurance
☐ No insurance ☐ Self-pay

Reason for referral/presenting problem:

Send referrals by email to mendingpoint@kyumh.org or by fax at (859) 241-3787

For questions about Mending Point services call (859) 523-3001 or (859) 523-4650