Open Arms Community Mental Health Center

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Miami, Florida 33150

Office 7866152166 Fax 7866168123 EFax 8663490524

www.openarmscmhc.com

Date of Referral: _____

Referral Source: _____

Last Name: _____ **First Name:** _____

Address: _____

Contact Number: _____ **Cell:** _____

Client name: _____

SS# _____ **D.O.B.** _____

Address: _____

Home phone: _____ **Cell:** _____

Legal Guardian: _____

Guardian Phone: _____

Case Manager (If App) _____

Insurance Information

Medicaid Number: _____ **Insurance ID #**_____

Third party Insurance _____ **Self Pay** _____

Reason for Referral:

_____

Services Requested: ____Anger Management _____Psychiatric Evaluation ____ Sexual Abuse

____Bio-Psychosocial Assessment_____ Psychological Assessment _____ADHD _____ Autism Grief/Loss_____ Targeted Case Management ____Substance Abuse _____Depression _____ Anxiety _____ Self-esteem _____ Bullying _____Individual Therapy _____ Family Therapy _____School-Based Counseling _____ Trauma Assessment _____ Peer Pressure