Referral for Child and Adolescent Behavioral Health Services

Information about individual being referred (please print)

Name: _____ Referral Date: ___/___/_____

Address: _____ City: _____ Zip Code: _____

County: _____ Telephone: _____ Birthdate: ___/___/_____ Age: _____

Guardian: _____ (check one) _____ Parent _____ DFCS _____ Other

Referring agency or organization: _____

Contact Person: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Caseworker: _____ Phone: _____

Attorney: _____ Phone: _____

Services requested (check all that apply):

____ Mental Health Services ____ Addiction/Substance Abuse ____ Community Support Services

Please describe reason/circumstances of referral:

_____

_____

_____

_____

_____

_____

Signature of individual or guardian _____

Signature of person making referral _____

Return completed referral form to:
Levurne Batts, CADC II; SOC Court Navigator Lead. Phone: (678) 451-6341
Scan and email completed form to: levurnebatts@highlandrivers.org
Or fax form to attn Levurne Batts at: (404) 795-2047.
An online interactive version of this form is available in English and Spanish at:
http://highlandrivershealth.com/referral-for-child-and-adolescent-behavioral-health-services/