Referral for Child and Adolescent Behavioral Health Services

NOTE: Please do not use this form for hospital discharge referrals; please CALL (678) 451-6341 to schedule.

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: _________________________

Services requested (check all that apply):

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

Attorney: ___________________________________ Phone: _________________________

Please describe reason/circumstances of referral:

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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/