THRIVE BEHAVIORAL HEALTH

Thrive Referral Form

AA County, PG County, Mo. County, and Howard County: Melissa Klaus mklaus@thrivebh.com Tel.: 410-780-5203 Fax: 410-987-4301
Baltimore and Harford County Referrals: Megan Holter mholter@thrivebh.com Tel.: 410-780-5203 Fax: 410-780-5205
Baltimore School Referrals: Megan Holter mholter@thrivebh.com Tel.: 410-780-5203 Fax: 410-780-5205
Thrive strives to acknowledge receipt of referrals within 3 business days. Please contact the office if not contacted within that time. Black ink only.

Returning Client: ☐ Yes ☐ No	☐ Female ☐ Male	Date:
Client Name:		Date of Birth:
SS#:	MA #	
Address:	Apt. #: City:	Zip Code:
*Social Security # must be known to complete intake		

Adult Client or Parent/Guardian:	Referral Source:
Name:	Name:
Guardian Relationship:	Relationship:
Home:	Agency/School:
Mobile:	Email:
☐Home ☐Group Home ☐Shelter ☐Foster Care ☐Homeless	Office: Mobile:

Screening Questions: ***If you answer yes to any of the following, please call our office to speak to an intake coordinator or supervisor prior to sending referral.***

1. Do you/your child/client have any thoughts or plan to harm or kill yourself/themselves? ☐ Yes ☐ No
2. Do you your child/client have any thoughts or plan to harm or kill anyone else? ☐ Yes ☐ No
3. Do you your child/client have any type of hallucinations? ☐ Yes ☐ No
4. Is there domestic violence in the home? ☐ Yes ☐ No
5. Is there a sexual offender residing in the home? ☐ Yes ☐ No
6. Are you/your child/client violent towards others? ☐ Yes ☐ No

If an emergency or urgent crises arises, call 911 or a crisis number such as Baltimore Crisis Response at 410-931-2214.

Please answer the following questions:

Is the consumer of Hispanic, Latino, or Spanish origin?	☐ Yes ☐ No ☐ Unavailable
Race:	☐White ☐ Asian ☐ Black/African American ☐American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Not Available
How well does the consumer speak English?	☐ Well ☐ Not so well ☐ Not at All
Does the consumer speak another language other than English at home?	☐ Yes ☐ No
If yes, what is the language?	☐ Spanish ☐ Other
Number of Arrests in the Past 30 days?	☐None ☐ 1-99
Is the consumer deaf or do they have hearing difficulty?	☐ Yes ☐ No ☐ Unknown
Is the consumer blind or do they have serious difficulty seeing, even when they wear glasses?	☐ Yes ☐ No ☐ Unknown

Reason for Referral: *Please give detailed description of symptoms/problems that are the reason for referral such as depression, anxiety, anger management, and mood lability. Please note any history of suicidal or homicidal ideation, aggression, self-harm, and/or hallucinations. Hospital referrals require discharge paperwork. DSS/DJS must complete intake paperwork and provide guardianship paperwork in order to process referrals if guardian will not be at intake.*

Internal Use Only-- M #:	EMR#:	Effective Date:	SIO?: