



CALVARY
PLACEMENT AGENCY

Referral & Consent

Free Mental Health Screenings | Nationwide
Email Referrals To: info@calvaryplacementagency.com
Admissions: 1-888-416-3633 | Fax: 972-292-9638

CLIENT INFORMATION Child (5-12 yrs) Adolescent (13-17yrs)

Client Name: _____ Date of Birth: _____

Parent/Guardian (If Applicable): _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Provider: _____ Subscribers Name: _____

Member ID / Group ID: _____

Email: _____

Recommendations for the Following Service (s)

Emergency Housing

Case Management

Other: _____

Diagnosis/Concerns: _____

CONSENT

**** PLEASE COMPLETE THIS SECTION****

Client's Release of Information: I authorize referral source to communicate with Calvary Placement Agency for the purpose of tele screening, communication, and scheduling my appointment. An authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicated with referring physician or referral source.

Client Signature: _____ Date: _____

Please check box if client provided verbal consent.

Referral Source Information ISD Court Provider Other

Person Making Referral: _____

Referral Organization: _____ Phone# _____

Office Contact Person: _____ Fax# _____

Email: _____

Calvary Placement Agency Area 1st Attempt ____ 2nd Attempt ____ 3rd Attempt ____

Appointment Scheduled: Date: _____ Time: _____

Client Unable / Declined to schedule: Reason: _____

Note: _____

Calvary Placement Agency team member completing this document: _____