Care Team Services Referral Form

Seasons provides services that intend to ***wrap around*** our clients while recognizing them as whole and complex persons with unique sets of needs. Services provided may include peer support, nursing support, health and wellness coaching, care coordination, case management, veterans/military-specific care coordination and therapy, readiness/recovery services, and in-home, in-community, in-office, or telehealth therapy! *Service eligibility will vary by the individual's county of residence, diagnosis, and needs.*

CLIENT INFORMATION			
Last Name:	**First Name:**		**Middle Initial:**
Address:			
City:	**State:**	**Zip Code:**	**County:**
Phone Number:	**Date of Birth:**		**Client Under 18:** YES ☐ NO ☐
Insurance Carrier & ID Number:		**Legal Guardian (if applicable):**	
Current Seasons Client: YES ☐ NO ☐	**If Current Seasons Client, Date Last Seen:**		**If Current Seasons Client, MRN:**
Reason for Referral:			
Is this client a veteran? YES ☐ NO ☐			
IF CHILD: **Is this client in foster care, in kinship care, or adopted?** YES ☐ NO ☐			
We require that clients are informed that they are being referred before the referral is made. **Does client know they are being referred?** YES ☐ NO ☐			

PSYCHIATRIC/MEDICAL INFORMATION		
Psychiatrist:	**Primary Care Provider:**	**Mental Health Therapist:**
Diagnoses (psychiatric & medical, if known):		

If you (as the referral source) are NOT a Seasons employee, please attach recent psychiatric, medical, clinical notes AND current medication list.

REFERRAL SOURCE INFORMATION	
First & Last Name of Person Completing Form	**Title of Person Completing Form**
Organization/Agency of Referrer(s) (if not Seasons)	**Others Involved in Referral**
Date of Referral	**Contact Information**

If you (as the referral source) are NOT a Seasons employee, please attach a release of information.
If a release of information is not attached, follow up cannot be provided.

Please email your completed form to careteam@seasonscenter.org.