COMMUNITY SERVICES GROUP
REFERRAL FORM

Ways to Submit Referrals:

1. Email: referrals@csgonline.org
2. Fax: 866.902.3285
3. Call: 877.907.7970 ext. 50014

Please complete this referral form in its entirety. Additionally, please send along the following information whenever possible:

☐ Psychiatric Evaluation ☐ Discharge Summaries ☐ Psychosocial History
☐ Psychological Evaluation ☐ Individual Support Plan ☐ Custody/Guardianship documentation
☐ Other:

REFERRAL SOURCE and CONTACT INFORMATION:

Referral Source Name and Agency	
Contact Name	
Contact Number or Email	

INDIVIDUAL DEMOGRAPHICS:

Legal Name	
Preferred Name	
Date of Birth	
Gender	☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male
Address	
Contact Number	☐ Home Phone ☐ Mobile ☐ Work
Social Security Number	
Insurance Name	
Insurance Number & Policy Group #	
Policy Holder Name (if different)	
Policy Holder DOB (if different)	
Policy Holder's Relationship to Individual	

REFERRAL INFORMATION:

Requested CSG Program(s) and Location	
Reason for Referral	
Diagnoses (ICD 10 or DSM 5)	

SUPPLEMENTAL INFORMATION FOR RESIDENTIAL REFERRALS:

ADDITIONAL INDIVIDUAL DEMOGRAPHICS:

Marital Status	☐ Single ☐ Married ☐ Co-Habitating ☐ Divorced ☐ Separated ☐ Widowed
Race & Ethnicity	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:
Living Arrangements	☐ Living Alone ☐ Living with Family ☐ Living with Others ☐ Living in Provider Operated Setting ☐ Living in Nursing Facility or Institution ☐ Homeless ☐ Other:
Legal Status	
Sources & Amounts of Income	
Emergency Contact Information	
Emergency Contact Relationship	
Has Ability to Self-Preserve	☐ Yes ☐ No

FOR PSYCHIATRIC REHABILITATION, PEER SUPPORT, AND CLUBHOUSE REFERRALS PLEASE COMPLETE THE FOLLOWING:

REASON FOR REFERRAL: PLEASE CHECK THE BOX TO IDENTIFY THE FUNCTIONAL DOMAIN(S) WHERE IMPAIRMENT IS BEING SEEN AND PROVIDE AND EXPLAIN THE PROBLEMS BEING EXPERIENCED IN THIS/THESE AREA(S) –

Living	☐
Learning	☐
Working	☐
Social Skills	☐
Wellness	☐

I, as a practitioner of the healing arts (physician, licensed psychologist, physician's assistant, certified registered nurse practitioner), am recommending the service as medically necessary.

☐ *PSYCHIATRIC REHABILITATION SERVICES*

☐ *PEER SUPPORT SERVICES*

Printed Name and Title	
MA ID Number	
NPI Number	

_____ _____

Signature of Healing Arts Practitioner Date