ASIAN **HUMAN** SERVICES

Counseling Referral Form

Date: _____

Client Name: _____

Referring Provider & Staff Name: _____

Client Date of Birth: _____

Clients' Language: _____Insurance: Medicaid (RIN)_____
****Please provide a copy of the most recent Medicaid card****

Social Security Number: _____

F-Code & Diagnosis: _____

_____

Reason for Referral *(brief description of behavioral, social or emotional problems)*:
Please use additional pages for description if needed

Is there interest in supported employment services? ☐ Yes ☐ No

Details: _____

_____

Asian Human Services, Inc.
4753 North Broadway, Suite 700, Chicago, Illinois 60640 tel: 773.293.8430 fax: 773.728.4751 website: www.ahschicago.org

(By Signing below, I am attesting that this form has been reviewed and I am in agreement with corresponding document as I give my consent for Asian Human Services to verify my medical coverage, review the information on this referral form and to contact me regarding behavioral health services)

Print Name_____Client Phone # _____

Client Email: _____

Signature of Client _____Date of Signature _____

Please send this referral form to:

CC: Ha Tran – Program Manager htran@ahschicago.org
CC: Jonas Ginsburg – Clinical Manager jginsburg@ahschicago.org
CC: Zahidul Haque – AHS Uptown Intake Coordinator zhaque@ahschicago.org