Date of Referral: _____

LINC Referral Form

DEMOGRAPHIC INFORMATION		
Name:	***Case Number*** *(if applicable)*:	***SSN***:
Address:		
(A) ***Ok to mail to this address:*** *Yes ☐ No ☐* *(B)* ***Moved in past three (3) months:*** *Yes ☐ No ☐* *(C)* ***Type of Residence:***		
Client Phone:	***Client Email***:	
(A) ***Ok to call?*** *Yes ☐ No ☐* *(B)* ***Ok to email? :*** *Yes ☐ No ☐*		
Date of Birth:	***Age***:	***Marital Status*** *(if applicable)*:
Are you currently in school? *Yes ☐ No ☐*		***If yes, what current School and Grade?***
		If no, what is your highest education?
Gender at Birth: *M F ☐*		***Preferred Pronouns***:
Race/Ethnicity:	***Hispanic***: *Yes ☐ No ☐ N/A ☐*	***Preferred Language***:
Referral Source:		***Employed:*** *Yes ☐ No ☐ N/A ☐*
Insured: *Y ☐ No ☐ N/A ☐*	***Insurance Company***:	***Insurance ID #***:
Military Status:	***Family in Military***: *☐ No ☐ N/A ☐*	***Current Legal Status*** *(Voluntary, Court Ordered, etc.)*:
Parent/Legal Guardian Name (if applicable):		
Parent/Legal Guardian Phone:	***Parent/Legal Guardian Email***:	
Primary Emergency Contact Name (if applicable):		
Primary Emergency Contact Phone:	***Primary Emergency Contact Email***:	

PRESENTING CONCERNS AND DIAGNOSIS	
***Presenting Concerns (Symptoms of psychosis and duration of symptoms)**:*	
Medical Conditions (if applicable):	
***Diagnoses (if applicable)**:*	***ID/Autism**: Yes ☐ No ☐ N/A ☐ -*
***Current Medications (if applicable)**:*	
***Active Substance Abuse**: Yes ☐ No ☐ N/A ☐*	***Trauma History**: Yes ☐ No ☐ N/A ☐*
***Additional Comments**:*	

Please submit to via Mail/Fax/Secure email to:

Central Access Team
10455 White Grantie Dr, Suite 400
Oakton, VA 22124
Phone: 571-759-HOPE (571-759-4673)
Fax: 703-448-3723
Email: CentralAccess@hopelinkbh.org