Hillsborough County
Ph: 813-443-4827
Fax: 813-443-4828

Pinellas County
Ph: 727-231-4885
Fax: 727-255-5683

Pasco County
Ph: 352-205-4788
Fax: 352-397-4466

referrals-north@chrysalishealth.com

CHRYSALIS HEALTH REFERRAL FORM

PROGRAM: Outpatient

Name of Person Referred: _____

DOB:_____ SSN/ Medicaid #: _____ Gender: _____

Reason for Referral: _____

Has Person Referred Received Services from Chrysalis Before: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County:_____

Preferred Phone#: _____ Other Phone#: _____ Other Phone#: _____

Legal Guardian: _____ Relationship to Person Referred: _____

Legal Guardian Preferred Phone#: _____ Other Phone#: _____

Other Contact: _____ Relationship to Person Referred: _____

Other Contact Preferred Phone#: _____ Other Phone#: _____

Emergency Contact: _____ Emergency Contact Phone#: _____

Is Person Referred in School: _____ If yes, Name of School: _____

Is Person Referred Residing in Group or Therapeutic Foster Care:____ If yes, with Whom:_____

Is Person Referred Currently Receiving Therapeutic Services:___ If yes, from Whom:_____

Limited English Proficiency: □Yes □No If yes, who: □ Person Referred □Family □Other: _____

Preferred Language for Assessment: _____ Preferred Language for Services: _____

□Visually Impaired □Hearing Impaired □Auxiliary Communication Aids desired: _____

Race:
□White
□African American
□White Hispanic
□Multi-Racial
□Hispanic of African American Descent
□American Indian
□Asian or Pacific Islander
□Alaskan Native
□Native Hawaiian
□Other

Ethnicity: □Puerto Rican □Mexican □Cuban □Other Hispanic □Haitian □None

Insurance/Funding: _____ Policy/Member ID: _____

Referred By (Name): _____Referral Source (Agency): _____

Phone#: _____ Email: _____

If Self Referred, How Did You Hear About Us?_____

_____ _____

Name/Title of Person Completing Form Signature Date