



For Office Use Only:	
<input type="checkbox"/> OBHS	<input type="checkbox"/> CSP
Site: _____	Date: _____

**CENTER FOR HUMAN DEVELOPMENT | CENTRAL REGISTRATION
TRANSITION OF CARE INTAKE FORM**

Please complete the following information, printing clearly:

Referral Information:

PBHH Program:	Contact Name:
Contact Information <i>(telephone)</i> :	Preferred Appointment Days: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa
Preferred Times: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	Prefer to see a female or male therapist: <input type="checkbox"/> Male <input type="checkbox"/> Female
Possible Substance Use Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	Outreach services requested: <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for transition/presenting problem: Dx:	

Client Information:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Gender:
Preferred Language:	Race:	Ethnicity:
Mailing Address:	City, State & Zip Code:	
Telephone Number:	OK to leave message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Legal Guardian: <i>(if applicable)</i>		

Insurance Information:

Insurance Name:	Member ID:	
Subscriber's Information <i>(if different than self)</i> Name:	Subscriber: Date of Birth: --/--/---- Social Security Number: ---/--/----	
Subscriber Mailing Address:	City, State & Zip Code:	
Telephone Number:	OK to leave message: <input type="checkbox"/> Yes <input type="checkbox"/> No	