For Office Use Only:
❑ OBHS ❑ CSP
Site: _____________ Date:________

CENTER FOR HUMAN DEVELOPMENT I CENTRAL REGISTRATION
TRANSITION OF CARE INTAKE FORM

Please complete the following information, printing clearly:

Referral Information:

PBHH Program:	Contact Name:
Contact Information *(telephone)*:	Preferred Appointment Days: ❑ M ❑ T ❑ W ❑ Th ❑ F ❑ Sa
Preferred Times: ❑ Morning ❑ Afternoon ❑ Evening	Prefer to see a female or male therapist: ❑ Male ❑ Female
Possible Substance Use Treatment: ❑ Yes ❑ No	Outreach services requested: ❑ Yes ❑ 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: ❑ Yes ❑ No	
Legal Guardian: *(if applicable)*		

Insurance Information:

Insurance Name:		Member ID:
Subscriber's Information *(if different than self)* Name:	Subscriber: Date of Birth: --/--/---- Social Security Number: ---/--/----	
Subscriber Mailing Address:	City, State & Zip Code:	
Telephone Number:	OK to leave message: ❑ Yes ❑ No	