



**ACADEMY at GLENGARY**  
 1819 Glengary Street  
 Sarasota, FL 34231  
 Tel: (941) 921-9936  
 Fax: (941) 922-2133

**REFERRAL FORM**

- Membership Requirements:**
1. Referral Form signed by licensed clinician
  2. Psychiatric Evaluation (most recent)

**PROSPECTIVE MEMBER INFORMATION**

(name)	(date of birth)		
(address)	(social security number)		
(city)	(state)	(zip code)	(phone number)

**DIAGNOSIS**

Primary Dx:	
Secondary Dx:	
Tertiary Dx:	
GAF (if known):	

Traumatic Brain Injury	<input type="checkbox"/> yes <input type="checkbox"/> no
Autism Spectrum Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Developmental or Intellectual Disability	<input type="checkbox"/> yes <input type="checkbox"/> no

Reason for Referral/Goals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RISK ASSESSMENT:**

BEHAVIOR	HISTORY	CURRENT ACTIVITY LEVEL			
violence	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> none	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> high
suicide attempt(s)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> none	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> high
alcohol/drug abuse	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> none	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> high
sexual exploitation	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> none	<input type="checkbox"/> minimal	<input type="checkbox"/> moderate	<input type="checkbox"/> high

Describe any legal involvement: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PSYCHIATRIST INFORMATION - PLEASE FILL OUT COMPLETELY**

(name)	(phone)		
(address)	(date)		
(city)	(state)	(zip code)	signature

*(use additional paper, if necessary, for any aspect of this referral form)*

