Adkins Counseling Services

151 N 3rd Ave, Suite 400
Pocatello, ID
(208) 840-1992

REFERRAL FOR TREATMENT

Client Name:		Date:
DOB:	Medicaid ID:	
Caregiver Name:	Relationship to Client:	
Address:		Phone:
Current living situation:		
Referred by:	Referred phone number:	

Youth is aged 11-17.5?	☐Yes ☐No
Youth has Idaho Medicaid?	☐Yes ☐No
There is at least one parent/guardian/caregiver willing to participate in treatment?	☐Yes ☐No

Youth has high needs as indicated by:

☐At risk for out of home placement or hospitalization

☐Involvement in multiple systems

- Which systems? _____

☐Behavioral health concerns coupled with abuse, neglect, or other forms of trauma

☐Delinquency, truancy, or running away

☐Substance use

☐Other:

Please describe the Current Concerns:

Please send this form to Adkins Counseling Services,
Josie@adkinscounseling.com
or fax to (208) 550-3462