Children's Solutions
P.O. Box 1078 • Jackson, MS 39215
Phone: 800.388.6247 • Admission's Fax: 601.709.1219

REFERRAL FORM

Date: ______________________

Information about the person being referred:

Name:____

DOB: _________________ Age: ___________ Gender:_______ Race: ________Social Security #: _____________________

Please check the program the individual is being referred to:

- ☐ Canopy Outpatient Behavioral Health Solutions (Clinic-Based Therapy/Medication Management)
- ☐ Canopy Early Intervention Autism Clinic (Clinic-Based Autism Assessment/Therapy)
- ☐ CARES Center (Psychiatric Residential Treatment Facility/PRTF)
- ☐ MYPAC (Intensive In-Home Services)

Parent/Caregiver Information:

Parent/Caregiver Name: ____ Relationship to the Individual: ____________

Current Address: ____

City: _____________________________ State:_____ Zip: ___________ County: ______________________________

Telephone ____ Email: ____

In DHS Custody? ☐ Yes ☐ No If yes, please provide: Social Worker's Name:_____________________________

Telephone: ____ Email:____

Insurance Information:

Name of Insurance: _______________________________ Medicaid/Insurance #:___________________________

Name of the parent/guardian insurance is listed under: _____________________ Relationship to the Referred: ___________

To your knowledge have any services been received through Canopy Children's Solutions prior to this referral? ☐ Yes ☐ No

What are the reasons or primary behavioral challenges resulting in this referral?_____________________________________

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Contact information for the person making this referral:

Name: ____________________________________ Organization:______________________________________

City: _____________________________________ State:_________ Zip: ________________________________

Telephone ____ Email: ____