



# Pulaski County Navigator Referral Form

**Print Name:** \_\_\_\_\_

**Date of Appointment:** \_\_\_\_\_

**Consent Signed:**  Yes  No

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**ZIP Code:** \_\_\_\_\_

**Insurance Type:** \_\_\_\_\_

**Best Way to Contact:**

Call  Email  Text

**Pending Court Case(s):**

---

---

---

## Consent to Release Mental Health Information

I authorize the Pulaski County Navigator(s) to disclose and/or obtain information from agencies, individuals, and/or providers discussed during my appointment. *(Please initial one)*

Yes \_\_\_\_\_

No \_\_\_\_\_

---

## Supportive Services Needed

*(Please check all that apply)*

Evaluation

Therapy

- Medication Management
  - In-Patient
  - Intensive Outpatient
  - Residential
  - Detox
  - Insurance Assistance
  - Housing
  - Food Assistance
  - Transportation
  - Case Management
  - Legal Assistance
  - Financial Aid
  - Medical Assistance
  - Mental Health Services
  - Other: \_\_\_\_\_
- 

## Diagnosis

*(Please check all that apply)*

- Anxiety
  - Depression
  - Bipolar Disorder
  - Schizophrenia
  - Substance Use Disorder
- 

I authorize Pulaski County Navigator(s) to contact agencies, individuals, and/or providers discussed during my appointment. *(Please initial one)*

- Yes \_\_\_\_\_
  - No \_\_\_\_\_
- 

I understand that this consent is subject to written revocation by me at any time. This consent will expire upon termination of my involvement in the Navigator Program. *(Please initial one)*

Yes \_\_\_\_\_

No \_\_\_\_\_

---

I understand that I have read and consented to this form, or have had this consent form explained to me, and understand its composition and purpose. I understand my signature is voluntary.  
*(Please initial one)*

Yes \_\_\_\_\_

No \_\_\_\_\_

---

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

---

## Other Information

### Topic / Focus

*(Please check all that apply)*

Grief

Domestic Violence

Sexual Abuse

Sexual Assault

Suicidal Ideation

Substance Abuse

Trauma

Sexuality

Relationship / Family Conflict

Anger

Self-Esteem

Eating Disorder

Academic Pressure

Religious Conflict

Other: \_\_\_\_\_

---

# Age Group

- Child
  - Preteen (12–15)
  - Teen (16–18)
  - Adult
- 

## Minor Consent

If under 18, a parent/guardian must be present and sign for services.

**Parent/Guardian Signature:** \_\_\_\_\_

**Relationship to Minor:** \_\_\_\_\_

---

## Provider Preferences

**Preferred Provider Gender:**

- Male     Female     No Preference

**Service Type:**

- In Person     Telehealth

**Travel Preference:**

- Local Only  
 Willing to Travel

**If travel is required, is transportation needed?**

- Yes     No

**Other Preferences:**

---

---

# Availability

*(Please check all that apply)*

- Morning
- Afternoon
- Evening
- Weekends

## Available Days:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday

## Other Availability Notes:

---

---