EMPOWERING YOU
FOR A POSITIVE CHANGE

CLIENT REFERRAL FORM

☐ **Intensive In-Home Services** ☐ **Mental Health Skill Building** ☐ **Out-Patient Services**

Identifying Information:			
Referral Date:	Initial Contact Date:		
Client Name:	DOB:	Age:	SS#:
Address *(City/State/Zip Code)*:			
Phone#:	Email Address:	Race:	
Gender: ☐ Male ☐ Female	Insurance Name#:	Insurance ID#:	
Parent/Legal Guardian *(for minors only)*:	Name:	Phone#:	
Parent/Legal Guardian Address *(City/State/Zip Code)*:			
Relationship:	Parent/Legal Guardian Email Address:		

Current Problems and Services

1. Problems or reasons for referral?

2. Has the individual received any mental health services over the last 30 days ☐ Yes ☐ No *(if "yes," please specify)*:

3. Does the individual have a current or historical diagnosis? ☐ Yes ☐ No *(if "yes," please specify)*:

4. Has the individual had mental health services before? ☐ Yes ☐ No *(if "yes," please specify)*:

5. Has the individual seen a psychiatrist or psychologist? ☐ Yes ☐ No *(if "yes," please specify)*:

6. Individual has any Medicaid? ☐ Yes ☐ No

Describe individual's disposition *(does individual need other services outside of EYPC Programs/further assessments/evaluation?)*:
☐ Yes ☐ No If "Yes" please include facility name/address/phone#:

Other facility information: Contact made? ☐ Yes ☐ No

Individual admitted? ☐ Yes ☐ No	On the waiting list? ☐ Yes ☐ No

If on waiting list, please indicate other appropriate services/facility referred *(please include facility name/address/phone#)*:

Is individual registered as a sex offender? ☐ Yes ☐ No. If yes *(include Parole Officer's information below)*

Parole Officer Name:	Parole Officer Phone#:
Person making referral:	Phone#:
Agency Name (if applicable):	Date:

Medication:

Name of Medication	Dosage	Frequency	Prescribed by

Treatment History/Facility: What facilities has the client been admitted to and mental/behavioral health services in the past 90-day period? Exact dates and locations

Medical: Who is the pediatrician or other physician that has provided services to the client? *(please include name, phone numbers)*

Risk of Harm: What behaviors do you have? (i.e., physical/verbal aggression, suicidal behavior, homicidal behaviors, property destruction, following directions, symptomatic behaviors (depression, anger outbursts, etc.), etc.? How often and what is duration/severity of behavior?

Who is your psychiatrist? _____ **Phone#**_____

Who do you see for Outpatient therapy? _____ **Phone#**_____

Functional Status: How does client do with hygiene, cleanliness, organization, school participation, social skills, etc.?

Natural Support in the Environment: who is the client's support including family and other resources outside of the home? Has there been other agency involvement including family services (i.e., DSS), school, etc.?

Level of Care: Acceptance and Engagement: What does the client and parent/guardian say client needs to be successful?

Transportation Available: What transportation services can the client use? Who transports the client when needed?

History: What are some significant historical issues involving family members, when did parent/guardian notice onset of symptoms/behaviors?

House Pets: Do you have pets in the home? ☐ Yes ☐ No ☐ N/A. If **'Yes'** *(please specify)*:

Presenting Problem: What are problems that brought the client to the service?

_____ _____

Staff Name *(please print)* & Signature Date