Referral Information

Date of Referral:	Time of Referral:	Program Referred To:
Referring Agency:		
Contact Person:		
Phone:		
Agency Authorizing Placement:		
Relationship to Child:		
Reason for Referral:		

Client Information

Name:		Date of Birth:
Gender: ☐ Male ☐ Female		Social Security #:
Height:	Weight:	Allergies:
Current Medications:		
Cultural Affiliation:		Religious Affiliation:
Where is the client living?		
Mother's Name:		
Mother's Address:		
Mother's Phone:		
Father's Name:		
Father's Address:		
Father's Phone:		
Step Parent(s)?		
Legal Guardian?		Custody?
Current Educational Placement: ☐ Regular ☐ Alternative ☐ Special (☐ES, ☐LS, ☐ Life Skills)		IQ:
School District:		Grade:
Is the child currently receiving services? ☐ Yes ☐ No		If yes, what:
Previous Placement History:		
Is the client ambulatory? ☐ Yes ☐ No	Medically Fragile? ☐ Yes ☐ No	Self-Preserving? ☐ Yes ☐ No
Most recent diagnosis (date/physician): *Axis I:* *Axis II:* *Axis III:* *Axis IV:* *Axis V:*		

Admission Criteria Information

Criteria	24 Hours	3 Months	6 Months	Explanation
Suicidal	☐	☐	☐	
Physical Abuse	☐	☐	☐	
Sexual Abuse	☐	☐	☐	
Psychological Abuse	☐	☐	☐	
Self-Injurious	☐	☐	☐	
Homicidal	☐	☐	☐	
Run Away	☐	☐	☐	
Fire Setting	☐	☐	☐	
Violence Towards Others	☐	☐	☐	
Legal Charges	☐	☐	☐	
Sexual Offending	☐	☐	☐	
Eating Disorders	☐	☐	☐	
Violence Towards Property	☐	☐	☐	
Stealing	☐	☐	☐	
Psychosis	☐	☐	☐	
Rapidly Shifting Ideas	☐	☐	☐	
Frequent Mood Changes	☐	☐	☐	
Drug & Alcohol Issues	☐	☐	☐	
Truancy Issues	☐	☐	☐	

Billing Information

County of Residence:	
Insurance: ☐ Fee for Service ☐MCO ☐ CCBH ☐ VBH ☐ Magellan ☐ CBHNP ☐HIPP	
Care Manager:	
Does the child have MA? ☐ Yes ☐ No	
Card #:	Issue #:
Private Insurance: ☐ Yes ☐ No	ID/Group #:
Contact Person:	Phone:

Summary Information

Summary:
Accepted: ☐ Yes ☐ No
Date Completed:
Completed By:
Reviewed By:
Administrative Signature(s):
Treatment Team Signatures: