

## REFERRAL FORM

(IF YOU DO NOT HAVE ENOUGH LINES FOR INFORMATION PLEASE ATTACH ADDITIONAL PAGES OR WRITE ON BACK OF PAGES)

Client Name: \_\_\_\_\_ Record #: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_

Age: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security #: \_\_\_\_\_

Medicaid/Medicare Card #: \_\_\_\_\_

Financial Support: SSI Medicaid CAP Private Pay Other: \_\_\_\_\_ (Circle One)

Other agencies involvement with family: \_\_\_\_\_

**Legal Guardian:** \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Caregiver Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Directions to Client's House/Placement: \_\_\_\_\_

Services Requesting:  all that apply  Community Support Child  Community Support Adult  Assertive Community Treatment  Targeted Case Management  Intensive In-Home Service  Diagnostic Assessment  Residential Treatment  Individual Therapy  Group Therapy  Family Therapy  Residential Treatment Children Level \_\_\_\_ Male/Female

Family Involvement: (Include Strengths & Weakness) \_\_\_\_\_

Siblings, Birth date, Telephone #'s, and Address: *Residential Only*

Does application carry any contagious disease (s)? If so list \_\_\_\_\_

**Medications:** (Brand Name, Strength, Dosage, Route) \_\_\_\_\_

Current Diet: \_\_\_\_\_ **Allergies:** \_\_\_\_\_

Seizure: No \_\_\_ Yes \_\_\_ Type and Frequency: \_\_\_\_\_

Most Recent IQ Score: \_\_\_\_\_

Handicaps: List and briefly explain any **handicapping** condition, **medical** or **behavioral** problems: \_\_\_\_\_

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**Placement History:** (Ex. Foster Care, Group Home, Respite, Hospitalizations etc) Give duration, amount of times, & date.

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**Religious Preferences:** Please describe any cultural observances we should know

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**Interest & Hobbies:** \_\_\_\_\_

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**Reason for Placement/Services:** \_\_\_\_\_

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History of abuse or neglect within the family, parent, and/or siblings?

Has the client ever been abused (physically/sexually) or neglected? By whom?

Does the client and/or family members have a DSM IV diagnosis or show signs of other emotional illness including drug/alcohol abuse?

Is the client or family currently receiving therapy/counseling? With whom and how often?

Has the client has a Psychological/Neurological evaluation? Give date (s):

Is the client in a specialized school placement: (BEH, LD, MR, etc.) Where?

Has the client been referred to Juvenile Court/Court?

Does client have a visiting resource?

Give names, address, and telephone number:

Does the client have a mentor: (Big brother/Big sister)

Give name, address, and telephone number:

**Annual Income Range for Family:**  15,000 or under  15,001-25,000  25,001-35,000  35,001-50,000  50,001-65,000  65,001-80,000  80,001-100,000  Over 100,000

**Sources of Income for Family:**  Employment Income  Social Security  TANF  AFDC  Child Support  Supplemental Security Income

## DEVELOPMENT STATUS

*RESIDENTIAL ONLY*

Ambulation: Walks Well\_\_\_\_ With Difficulty\_\_\_\_ Uses Walker\_\_\_\_  
Does Not Walk\_\_\_\_ Uses Wheel Chair\_\_\_\_ Crutches\_\_\_\_  
Cannot Sit Alone Capable of Bed to Chair Transfer\_\_\_\_

Vision: Normal\_\_\_\_ Mild Loss\_\_\_\_ Moderate Loss\_\_\_\_  
Severe Loss\_\_\_\_ No Vision At All\_\_\_\_ Undetermined\_\_\_\_

Hearing: Normal\_\_\_\_ Mild Loss\_\_\_\_ Moderate Loss\_\_\_\_  
Severe Loss\_\_\_\_

Speech: Can express language clearly\_\_\_\_  
Uses expressive language with difficulty\_\_\_\_  
Does not intentionally express self\_\_\_\_  
Uses Sign Language\_\_\_\_  
Attends to gestures and/or auditory cues\_\_\_\_  
Responds to communication\_\_\_\_  
Does not respond to communication\_\_\_\_

Dressing: Completely dresses self\_\_\_\_  
Completely dresses self with verbal prompts\_\_\_\_  
Pulls off or puts on clothes with help\_\_\_\_  
Must be dressed\_\_\_\_

Eating Skills: Uses Utensils correctly\_\_\_\_  
Feeds self with utensils appropriately\_\_\_\_  
Feeds self with considerable spilling\_\_\_\_  
Feeds self with fingers\_\_\_\_  
Does not chew\_\_\_\_

Toileting: Never has accidents\_\_\_\_  
Occasionally have accidents during the day\_\_\_\_  
Occasionally have accidents during the night\_\_\_\_  
Is not toilet trained\_\_\_\_

Socializing Interacts with peers\_\_\_\_ Does not interact\_\_\_\_  
Interact with others\_\_\_\_ Does not interact\_\_\_\_  
Initiates interactions\_\_\_\_ Does not initiate\_\_\_\_

Behavioral Concerns: Aggressive Verbal\_\_\_\_ Physical\_\_\_\_ Other\_\_\_\_  
Self Injurious\_\_\_\_ Injurious to others\_\_\_\_  
Non-compliant\_\_\_\_ Wanders\_\_\_\_

**DIAGNOSIS INFORMATION**

**Date of Diagnosis:** \_\_\_\_\_

	<b>Code</b>	<b>Diagnosis</b>	<b>Primary Diagnosis</b>
<b>Axis I</b>	_____	_____	_____
	_____	_____	_____
<b>Axis II</b>	_____	_____	_____
	_____	_____	_____
<b>Axis III</b>	_____	_____	_____
	_____	_____	_____
<b>Axis IV</b>	_____	_____	_____
	_____	_____	_____
<b>Axis V</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

*RESIDENTIAL ONLY*

Response  
(Circle one)

**Behaviors**

- Yes No Enuresis or Encopresis: If yes, details:
- Yes No Smoking
- Yes No Sexually active: If yes, details:
- Yes No Currently uses birth control
- Yes No Pregnancy: If yes, detail outcome:
- Yes No Suicide attempts: If yes, details:
- Yes No Threat of homicide: If yes, details:
- Yes No Violent/aggressive/destructive including self- injury
- Yes No Runaway (detail frequency & duration of each episode)
- Yes No History of stealing/shoplifting
- Yes No Truancy
- Yes No Suspended/expelled from school
- Frequency:
- Reason (s):
- Yes No Homosexual behaviors: If yes, details
- Yes No Drug/alcohol use: Received or receiving treatment? Where?

Explanations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by/Date: \_\_\_\_\_

Supervisor Signature/Date (EOL): \_\_\_\_\_

Envisions of Life Staff Only:  Placed on the waiting list  Not appropriate for services  Will start services on \_\_\_\_\_

\*\*\*\*PLEASE COMPLETE THE PCP ADMISSION ALSO WITH THIS FORM\*\*\*\*

