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: _____
Phone:_____
Preferred Name: _____ DOB: _____ Race: _____
Age: ___ Height _____Weight____Gender_____ Social Security #: _____
Medicaid/Medicare/Insurance 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* ☐*Assertive Community Treatment* ☐*Diagnostic Assessment* ☐*Individual Therapy* ☐*Group Therapy* ☐*Family Therapy* ☐*Residential Treatment Children Level 3* ☐*School Based Mental Health*

Family Involvement: (Include Strengths & Weakness) _____
_____
_____
_____
Siblings, Birth date, Telephone #'s, and Address: *Residential & SBMH 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: _____

Disabilities: List and briefly explain any **disabling** condition, **medical** or **behavioral** problems: _____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

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

_____

Interest & Hobbies: _____

_____

Reason for Placement/Services: _____

_____

_____

History of abuse or neglect within the family, parent, and/or siblings? ☐Yes ☐ No

Has the client ever been abused (physically/sexually) or neglected? ☐Yes ☐ No By whom?

Does the client and/or family members have a DSM 5 diagnosis or show signs of other emotional illness including drug/alcohol abuse?

Is the client or family currently receiving therapy/counseling? ☐Yes ☐ No With whom and how often?

Has the client has a Psychological/Neurological evaluation? ☐Yes ☐ No Give date (s):

Is the client in a specialized school program/service: (EC, OHI, 504 plan, etc.) Where?

Has the client been referred to Juvenile Court/Court? ☐Yes ☐ No **If yes PO name**

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 ☐Child Support ☐ Supplemental Security Income

DEVELOPMENT STATUS

RESIDENTIAL ONLY HOWEVER COMPLETE IF NEEDED

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: _____

CPT	**& ICD10 Code**	**Diagnosis**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RESIDENTIAL & SBMH 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**

Rev 8/19