

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: _____

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

Interest & Hobbies: _____

Reason for Placement/Services: _____

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: _____

	Code	Diagnosis	Primary Diagnosis
Axis I	_____	_____	_____
	_____	_____	_____
Axis II	_____	_____	_____
	_____	_____	_____
Axis III	_____	_____	_____
	_____	_____	_____
Axis IV	_____	_____	_____
	_____	_____	_____
Axis V	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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****

