REFERRAL FOR RESIDENTIAL TREATMENT

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CLIENT INFORMATION			
Client Name:	Sex: Male Female		Date of Birth
Address:	City:	State:	Social Security Number:
Race: White Black Alaskan Native/American Indian Native Hawaiian/Other Pacific Islander Asian			
Provider Name: Position: Contact Number: Date:			
Provider Email:			
Client needs interpreter or assistive technology: YES NO Specify: If YES: Language Interpreter American Sign Language Assistive Adaptive Device			
PASSE or INSURANCE	Member ID (if applicable)		
Guardian:	Relationship:	Phone:	
Current Living Situation:	Email:		
School:	Current Grade:	Special Education? YES NO School-based Services? YES NO	

DIAGNOSIS:	
1.	4.
2.	5.
3.	6.

REFERRING ISSUES:	
Victim of Human Trafficking? YES NO	Victim of Crime? YES NO
Court Involvement? YES NO FINS Petition	Legal Charges? YES NO
Problems being addressed from Treatment Plan: 1. 2. 3.	

Progress/Improvements that have been observed:

Describe current symptoms client is displaying in the school, community and/or home that cannot be managed safely in an outpatient treatment setting (specify if the behavior occurs in a particular setting):

REFERRING ISSUES

List types and dates of serious physically aggressive or destructive acts committed by the client in the last 30 days:

List types and dates of self-injurious or suicidal behavior in the last 30 days:

List the dates and length of stay of acute hospitalizations or residential treatment stays in the last 12 months:

List all agencies that are currently involved in the client's case (please include contact information):

Individual Therapy:	Date of last session:	Frequency:	Total # of sessions within last 90 days:

Family Therapy:	Date of last session:	Frequency:	Total # of sessions within last 90 days:
Medication Management:	Date of last session:	Are meds being refused? YES NO	
Crisis Intervention:	Provided within the last 6 months? YES NO	Was there a positive outcome? YES NO	
Other outpatient services received (service and frequency):			
What will occur in the residential setting to support client's return to family and community?			

REFERRAL SOURCE:	
Referral Source:	Location:
Name of Licensed Mental Health Provider:	

BEHAVIOR CHECKLIST				
Physical Aggression NONE Hits Kicks Bites Shoves Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Verbal Aggression NONE Curses Yells Screams Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Fire Setting NONE Plays with fire Fascinated by fire Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Homicidal attempt NONE Physically hurts others Weapons Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Homicidal Ideation NONE Talks about death Threatens others Plans to hurt others	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Self care risk NONE Refuses to bathe Won't get dressed	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Self –Injurious NONE Cuts self Burns self Hits self Head bangs	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Sexually inappropriate NONE Describe:	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Sexual perpetrator NONE Labeled Perpetrator Legal charges	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Suicide Attempt NONE Describe:	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Suicidal Ideation NONE Talks about death Drawings of death	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Anxiety and Panic NONE Fidgets Excessive worry Overly Hesitant	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Attachment Problems NONE Refuses nurturing Poor boundaries	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Binges or Purges NONE Overeats Vomits Hoards food	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Depressed Mood NONE Sad Hopeless Withdrawn	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Dissociative Behavior NONE Nightmares Flashbacks	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Impulsive NONE Act w/o thinking, Never considers consequences	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Lying and Manipulative NONE Doesn't tell the truth Exaggerates negative	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Oppositional NONE Refuses directions Lies about completing tasks	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Phobias (Including school phobia) NONE Describe:	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year

BEHAVIOR CHECKLIST				
Property destruction NONE Puts holes in walls Trashes room Tears up toys	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Running Away NONE Several hours Overnight Runs away from adult	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Social Withdrawal NONE Refuses activities No friends	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Stealing NONE Describe:	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Decreased Concentration NONE Inability to focus Distractible Day dreams	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Hyperactivity NONE Always moving Inability to sit still	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Distractible NONE Never on task Unfocused	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Paranoia NONE Thinks others are out to get them Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Poor Judgment NONE Chooses negative bx with obvious negative outcome	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Thought Disorder NONE Hears things Sees things	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Alcohol use/ abuse NONE Type of alcohol? Beer/wine Liquor	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
Drug use/Abuse NONE Marijuana Cocaine Meth Other	Frequency→ Last time it occurred→	Daily Last 30 days	Weekly 30-90 days	Monthly 90 days-1year
CURRENT MEDICATIONS				

PLEASE ATTACH THE FOLLOWING DOCUMENTATION TO THE REFERRAL:

Outpatient Treatment – Last 90 Days of Records

Acute Hospitalizations

Therapist Recommendation Letter

Psychiatric Evaluation