REFERRAL FOR RESIDENTIAL TREATMENT

THE CENTERS

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CLIENT INFORMATION

Client Name:	Sex: ☐ Male ☐ Female	Date of Birth

Address:	City:	State/ZIP:	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: Height: Weight IQ Special Education? ☐ YES ☐ NO
School-based Services? ☐ YES ☐ NO

DIAGNOSIS: MEDICAL AND MENTAL HEALTH:

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**