



Referral/Intake Form

Person completing form: _____ Date: _____ Phone: _____
Youth Name: _____ DOB: _____ Age: _____
SS# _____ County: _____ Race: _____ Ethnicity: _____
Medicaid# _____ Provider: _____ Height: _____ Weight: _____

CHILD HISTORY (check all that apply)

Physically aggressive: Yes No Describe: _____
Property Destruction: Yes No Describe: _____
Is the youth pregnant? Yes No
Does the youth have autism or have an IQ or 75 or below? Yes No
Substance Abuse: Yes No Describe: _____
Non-compliance with medications: Yes No
Psychiatric Hospitalization: Yes No Describe: _____
Violence or threats to self or others: Yes No Describe: _____
Depression: Yes No
Social or Developmental Delays: Yes No Describe: _____
Specific suicidal statements or actions: Yes No Describe: _____
Psychiatric Diagnoses: Yes No Describe: _____
Current non-psychiatric medical condition: Yes No Describe: _____
Recent change in mood or behavior: Yes No Describe: _____
Mental health history: Yes No Describe: _____
Academic or social difficulties: Yes No Describe: _____
Running away: Yes No Describe: _____
Domestic Violence: Yes No Describe: _____
Human trafficking: Yes No Describe: _____
Traumatic experiences: Yes No Describe: _____
Runaway behaviors: Never Rarely Often Frequently Chronic Describe: _____
Strengths: _____
Likes: _____
Allergies: _____
Birth Control: _____

CONTACT INFORMATION

Contact Person's Name: _____

Phone #: _____ Email: _____

Relationship to Applicant: _____

Address: _____

Date Placement Requested: _____

PSYCHIATRIC INFORMATION

Include all current/previous inpatient and outpatient treatment episodes, psychiatric hospitalizations and Baker Acts.

Where	Dates	Reason	Outcome

MEDICAL INFORMATION

Medication	Reason	Dose	Prescribed by

Is youth compliant with medication? Yes No If no, why? _____

Youth has a 30 day supply of psychiatric medication available? Yes No

Does youth have any recent medical concerns or hospitalizations? Yes No

If yes, describe: _____

DJJ/CRIMINAL HISTORY

Does the youth have any current or past DJJ involvement? Yes No If yes, please attach face sheet.

JPO Name: _____ Phone #: _____

Charges: _____

EDUCATION

Is youth currently enrolled in school? Yes No School Name/Grade: _____

If not enrolled, last school/grade attended? _____

Any school concerns/special placements/IEP? _____

DOCUMENTS NEEDED IF ADMITTED

If youth is admitted into the program, the documents below are expected.

- Copy of Social Security Card
- Copy of Birth Certificate
- Copy of up to date physical and dental exam
- All mental health records (including psychiatric evaluations, school evaluations, treatment summaries and discharge summaries from previous treatment facilities, IEP)
- Most recent Psychological and/or Psychiatric Report
- Most recent Staffing forms (Level of care, Multi-Disciplinary Team, Stability Staffing, Permanency Staffing, etc.)