



REFERRAL FORM

REFERRAL INFORMATION

Referral Source: _____ Contact Person: _____ Phone: _____

REFERRAL BEING MADE FOR:

- | | |
|---|---|
| <input type="checkbox"/> Evaluation Only | <input type="checkbox"/> BHRSCA (Wraparound) Services |
| <input type="checkbox"/> BHRSCA Brief Treatment (Wraparound) Services | <input type="checkbox"/> Service Coordination |
| <input type="checkbox"/> Family Based Mental Health Services | <input type="checkbox"/> Outpatient |

IDENTIFYING INFORMATION

Child's Name:	Date of Birth / Age:	Gender:
Address:	Phone:	Social Security Number:
County:	Insurance:	MA Number:
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian - Print race, for example, Hmong, Thai, Laotian, Cambodian		
<input type="checkbox"/> Black, African American or Negro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander Print race, for example, Fijian, Tongan <hr/> <input type="checkbox"/> American Indian or Alaska Native Print name of enrolled or principal tribe:		
<input type="checkbox"/> Other race – Print race: _____ <input type="checkbox"/> Declined to answer		
Ethnicity: Is the applicant for services of Hispanic, Latino, or Spanish origin? <input type="checkbox"/> No		
<input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Mexican, Mexican American or Chicano <input type="checkbox"/> Yes, Cuban		
<input type="checkbox"/> Yes, other Hispanic, Latino or Spanish Print origin, for example, Argentinean, Chilean, Dominican, Colombian		

FAMILY INFORMATION

Legal Guardian(s) / Relationship:	Biological Mother:	Biological Father:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Others Living in Household (please include name, age, and relationship to child)	Immediate Relatives Not Living in Household (please include name, age, and relationship to child)	

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EDUCATION			
School District:	School Building / phone #:	IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	Grade Level:
Educational Placement:		School Teacher:	
School Attendance	School Performance	School Behavior	Source of School Information
<input type="checkbox"/> Regular attendance <input type="checkbox"/> Sporadic attendance <input type="checkbox"/> Enrolled but rarely attends <input type="checkbox"/> Dropped out this quarter <input type="checkbox"/> Dropped out in a prior quarter <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable	<input type="checkbox"/> Above Average <input type="checkbox"/> Average <input type="checkbox"/> Below Average <input type="checkbox"/> Failing <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable	<input type="checkbox"/> No behavior problems <input type="checkbox"/> Occasional behavior problems <input type="checkbox"/> Constant behavior problems <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable	<input type="checkbox"/> Child <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> School system <input type="checkbox"/> Interagency meeting <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable

MEDICAL / PSYCHIATRIC HISTORY	
Physical Health Plan:	
Primary Care Physician:	Phone:
Psychiatrist:	Phone:
Psychologist:	Phone:
Current Mental Health Diagnosis:	Current Medications:
Axis I _____ _____	_____
Axis II _____	_____
Axis III _____	_____
Axis IV _____	_____
Axis V _____	_____
Has child had physical examination in past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has child had psychiatric/psychological evaluation in past 6 months?	<input type="checkbox"/> YES (if yes Date _____) <input type="checkbox"/> NO
Date of prescription for Mental Health Services: (Prescription must be attached)	Prescriber / Phone:

Previous and Current Mental Health Treatment	Dates of service	Provider/Contact Person & Phone #
<input type="checkbox"/> Service Coordination (please specify)		
<input type="checkbox"/> Outpatient		
<input type="checkbox"/> Partial		
<input type="checkbox"/> BHRSCA (wraparound)		

<input type="checkbox"/> Family-Based		
<input type="checkbox"/> Psychiatric hospitalization		
<input type="checkbox"/> Residential Treatment Facility		
<input type="checkbox"/> Other (please specify)		
SCU:	SCU Case Manager:	SCU Case Number:

REASON FOR REFERRAL

<input type="checkbox"/> Suicidal/homicidal ideation/self-injurious behavior	<input type="checkbox"/> Psycho-physiological condition (i.e. bulimia, anorexia nervosa)
<input type="checkbox"/> Impulsivity and/or aggression	<input type="checkbox"/> Psychosocial functional impairment
<input type="checkbox"/> Affection/function impairment (i.e. withdrawn, reclusive, labile)	<input type="checkbox"/> Thought impairment
<input type="checkbox"/> Psychomotor retardation or excitation	<input type="checkbox"/> Cognitive impairment
	<input type="checkbox"/> Substance abuse

*****Please include detailed information regarding psychiatric symptoms/behavior problems/significant psychosocial stressors that may interfere with child/family function:**

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages)

OTHER RELEVANT HISTORY / INFORMATION / SERVICE INVOLVEMENT

<input type="checkbox"/> CYF	Contact / phone:
<input type="checkbox"/> JP	Contact / phone:
<input type="checkbox"/> D & A	Contact / phone:
<input type="checkbox"/> MR	Contact / phone:
<input type="checkbox"/> Other	Contact / phone:

OTHER PERTINENT INFORMATION:

Drug/alcohol (MISA) screen was completed on _____ Diagnosis? _____ Last use _____ Plan for treatment _____

Screen for domestic violence in the home was completed on ____ Was screen positive? ____ Referrals were made to: _____

Is adolescent pregnant? _____ If yes, does she smoke cigarettes? _____

Does child have an Axis III diagnosis of obesity? _____

RISK

Is child at risk for out-of-home placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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At risk for what type of out-of-home placement?	<input type="checkbox"/> Psychiatric hospitalization	<input type="checkbox"/> RTF
	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Juvenile Court Placement
	<input type="checkbox"/> Other (please specify)	

Has parent agreed to service and signed a release of information:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Family recognizes the child's risk of out-of-home placement and the problems of maintaining their child at home without intensive therapeutic interventions in the context of the family?

Yes No

Is child returning home from an out-of-home placement and FBMHS is needed as a step-down? If yes, please describe.

Yes No

Treatment is determined by the treatment team to be necessary in the context of the family to effectively treat the child?

Yes No

ADDITIONAL COMMENTS/CONCERNS:

- ✓ All of the information on the referral form must be complete in order for the referral to be processed.
- ✓ If there is a question on the referral form that does not apply to the child/adolescent you are referring, please put N/A in the space.
- ✓ If an evaluation that prescribes the services you are requesting was already done please attach it to this referral form.

For inquires or questions:

Wiendi Allen, LPC – Intake Services Coordinator
 Phone: 412-390-3848
 Fax: 412-431-8124
 Email: wallen@PFQ.org

Behavior Symptom Checklist

Client Name:	Informant	Date				
Behavior Description		Frequency				
<i>Please check the box that best describes how frequently each of the listed behaviors occurs.</i>		<i>Always</i>	<i>Frequently</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>Never</i>
Runs about, climbs excessively, leaves seat in situations where remaining seated is expected.						
Gets bored after just a short while						
Daydreams or seems to be in another world						
Impulsive, trouble waiting turn, blurts out answers before the question is completed						
Difficulty in mixing with other children						
Difficulty playing quietly						
Prefers to be alone; some difficulty interacting with peers						
Insistence on sameness; resists changes in routine						
Hyperactive (fidgety, trouble staying seated)						
Tends to get sidetracked by what is going on around him or her						
Lacks attention to detail, trouble listening carefully to directions						
Forgetful or frequently misplaces or loses things						
Trouble sitting in one place too long, persistent sense of anxiety or nervousness						
Restless, fidgets with hands or feet; squirms in seat; always seems to be moving some part of their body						
Noticeable low level of activity						
Disorganized; has difficulty organizing tasks, daily schedule, activities						
Avoids or dislikes tasks that may require sustained mental effort (ie. reading, math exercises, homework)						
Sustained odd play						
Talks too much, interrupts, intrudes on other's conversations, talks when others are talking						
Homework not handed in, or doesn't finish things						
Easily frustrated with tasks demanding sustained mental effort (ie. schoolwork or homework)						
Fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.						
Says what comes to mind without considering the consequences.						

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Behavior Description	Frequency				
	Always	Frequently	Sometimes	Occasionally	Never
<i>Please check the box that best describes how frequently each of the listed behaviors occurs.</i>					
Difficulty falling asleep due to repeated thoughts and concerns					
Trouble going through proper channels or following proper procedures; Tends to be impatient					
Poor sense of time; Always late or in a hurry					
Often have piles of "stuff", easily overwhelmed by tasks of daily living					
Inappropriate laughing and giggling					
Seems to have more energy than others					
Does not seem to talk through problems, acts quickly without thinking first					
Over-reacts					
Tends to spin objects					
Trouble getting started or finishing tasks					
Easily overwhelmed					
Skips around while reading, goes to the end first, trouble staying on track					
Trouble learning new game or activity, has trouble following novel directions					
Blows up easily					
Unresponsive to normal teaching methods					
Trouble switching activities					
Little or no eye contact					
Often argues with adults					
Apparent insensitivity to pain					
Defies or refuses to comply with adult's requests or rules					
No real fear of dangers					
Suicidal ideations or attempts at self injury					
Displays extreme distress for no apparent reason					
Poor handwriting					
Not responsive to verbal cues; act as deaf					
Certain academic tasks seem difficult (specify)					
Seems deliberately spiteful, cruel or annoying					
Sensitive and easily annoyed by others					
Uneven gross/fine motor skills					
Anxious, edgy, stressed or painfully worried					
Often deliberately annoys people					

Behavior Description	Frequency				
	Always	Frequently	Sometimes	Occasionally	Never
<i>Please check the box that best describes how frequently each of the listed behaviors occurs.</i>					
Tends not to want to be cuddled or act cuddly					
Obsessive thoughts or fears; perseverative rituals					
Often blames others for mistakes or misbehavior					
Irritated for hours or days on end (not just frequent, brief blow-ups)					
Depressed, sad, or unhappy					
Abrupt mood swings					
Difficulty expressing needs; uses gestures or pointing instead of words.					
Often spiteful and vindictive					
Chronic sense of underachievement, disgusted because things never seem to go well					
Tends to be preoccupied with certain objects or ideas					
Tics: repetitive movements or noises					
Poor eye contact					
Immature or trouble sustaining effective relationships					
Frequently angry and resentful					
Does not catch on to social cues					
Limited range of interests and interactions					
Unusual sensitivity to sounds, touch, textures, movement or taste					
Coordination difficulties					
Threats of suicide (active or passive)					
Performance worsens under pressure					

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Please make any additional comments in this space.