A STEP AHEAD Program
Child and Adolescent Partial Hospital Program
Agency/School Referral Form
Referral for: ☐ Day Partial ☐ Therapeutic nursery ☐ Evening Partial

*Please note that referring agency must notify family/guardian of this referral*

Date of Referral: _____ Referred by: _____ Agency/School: _____ Phone: _____

PATIENT/GUARDIAN INFORMATION *Primary language of patient:* _____ *Primary language of parent/guardian:* _____

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ City: _____ Zip Code: _____

Medicaid #: _____ Other Insurance Info: _____

Guardian name: _____ Relationship to patient: _____

Address (If different than above): _____

Phone number(s): Home: _____ Cell: _____ Work: _____ Other: _____

EDUCATION

School: _____ Grade: _____ ☐ SpecEd ☐ RegEd Teacher: _____

Other Contact Person/Title: _____ Phone: _____

MEDICAL HISTORY

Primary Care Physician: _____ Phone/Address: _____

Diagnosis: _____ Allergies: _____

Current Medications: _____

REFERRAL REASONS & HISTORY OF PRESENTING PROBLEMS (check all that apply)

| | | | |
|---|---|---|---|
| ❒ Abuse victim | ❒ Depression | ❒ Anxiety | ❒ Defiant/oppositional |
| ❒ Sleep issues | ❒ Conflicts with parent | ❒ Autistic withdrawal | ❒ Conflicts with peers/siblings |
| ❒ Conflicts with parents | ❒ Temper tantrums | ❒ Parent education | ❒ Inattention |
| ❒ Hyperactivity | ❒ Eating issues | ❒ Running away | ❒ Disruptive behavior |
| ❒ Suicidal ideation | ❒ Homicidal ideation | ❒ Cognitive/Dev. Delays | ❒ Other: |

What strategies have been implemented to address these referral problems? _____

_____

_____

_____

_____ _____

Signature & Title of Referring Staff Print Name

*Please fax completed form*

A STEP AHEAD Program
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Agency/School Referral Form Follow-up

Child Name: _____ Referral for: ☐ Day Partial ☐ Therapeutic nursery ☐ Evening Partial

*Employee Use Only:* *Spanish Speaking Services Required* ☐ Yes ☐ No

MR #: _____ SS #: _____

Guardian DOB: _____ Guardian Social Security #: _____

Emergency Contact: _____ Address: _____

Relationship: _____ Phone: _____

Pharmacy: _____ Address: _____

Phone: _____

Other Service Providers

| Agency | Name | Phone Number |
|---|---|---|
| DCPP | | |
| Probation | | |
| Mental Health: _____ | | |
| Other: _____ | | |

NOTES/Disposition

Intake Date/Time:

Psych Eval Date/Time: