



# REFERRAL FORM

## Client Information

Referral Date \_\_\_\_\_ DOB \_\_\_\_\_

Child/Youth Name \_\_\_\_\_ Gender  Male  Female

Race  American Indian  Asian  Bi-racial  African American  Hispanic/Latino  Hawaiian  
 White  Other

Ethnicity  Central American  Cuban  Dominican  Mexican, Mexican American or Chicano  
 N/A (not Hispanic)  Puerto Rican  South American  Other Hispanic origin

Religion  Religion \_\_\_\_\_  Denomination (if known) \_\_\_\_\_  
 Non-denominational  Unknown  None

Spoken Language \_\_\_\_\_

Parents/Guardian Name(s) \_\_\_\_\_

Relationship to Child/Youth \_\_\_\_\_ Spoken Language \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

County \_\_\_\_\_ Parent E-Mail Address \_\_\_\_\_

## Referral Information

Referral Source/Agency: \_\_\_\_\_

Referring Staff Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

Summary of Reason for Referral/Behaviors of Concern: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is child/youth at risk of removal from preferred childcare or education setting?  Yes  No  
 If yes, give explanation: \_\_\_\_\_

Is child/youth at risk of disruption to preferred living situation?  Yes  No  
 If yes, give explanation: \_\_\_\_\_

Does the child/youth have any physical challenges or limitations?  Yes  No  
 If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Does the child have any special needs or delays? Yes No If yes, please explain: \_\_\_\_\_

List child and family strengths: \_\_\_\_\_

What help does your family need (use family's voice) \_\_\_\_\_

**Household Demographic Information**

**Income of Family:** Monthly \_\_\_\_\_ or Annual \_\_\_\_\_ SSI TANF Child Support \_\_\_\_\_

**Insurance of Child/Youth:** Medicaid (Type: HMO Traditional), CHIP, MAP,

Private Insurance: \_\_\_\_\_, None

**Living Arrangement of Child/Youth:** adoptive home biological father biological mother camp drug, alcohol RTC emergency shelter foster care group home home of friend home of relative independent/live by self independent/live with friend/partner individual home, emergency shelter ICF-MR jail/prison juvenile detention center living with a non-parent relative psychiatric hospital Residential Treatment Center two parent/caregivers

**Household Members:**

*Parent/Caregiver:*

Name \_\_\_\_\_ Relationship to child/youth \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child/youth \_\_\_\_\_

Marital Status of parents \_\_\_\_\_

*List any Parent residing out of the home:*

Name \_\_\_\_\_ Relationship to child/youth \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child/youth \_\_\_\_\_

*List siblings residing in the home:*

Name \_\_\_\_\_ Age \_\_\_\_\_

*List any siblings residing out of the home:*

Name \_\_\_\_\_ Age \_\_\_\_\_ Living where \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Living where \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Living where \_\_\_\_\_

*Other household members:*

Name \_\_\_\_\_ Relationship to Child/Youth \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child/Youth \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child/Youth \_\_\_\_\_

## Mental Health Status

### Current Diagnosis: DSM V

Date of Evaluation \_\_\_\_\_ Diagnostician \_\_\_\_\_ (Attach Evaluation)

Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

### Prior or DSM IV Diagnosis (if applicable):

Date of Evaluation \_\_\_\_\_ Diagnostician \_\_\_\_\_ (Attach Evaluation)

Axis I Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Axis II Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Axis III Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Axis IV Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Axis V Code \_\_\_\_\_ Diagnosis \_\_\_\_\_

Current Prescribed Medication	Amount	Year/Date Prescribed	Prescribing Physician
Prior Prescribed Medication	Amount	Year/Date Prescribed	Prescribing Physician

Has the child/youth been diagnosed as developmentally disabled:  Yes  No?

## Education Information

Name of School Child/Youth Attends \_\_\_\_\_ Grade \_\_\_\_\_

Name of School District \_\_\_\_\_ School ID# \_\_\_\_\_

School Contact Name \_\_\_\_\_ Contact Info \_\_\_\_\_

Special Education:  Yes  No  Referred  504 Accommodations \_\_\_\_\_

Disability:  ED  LD  OHI  Other \_\_\_\_\_

Services provided by Special Education:  Yes  No Date of last ARD: \_\_\_\_\_

If child/youth has not had an ARD has the LST been completed:  Yes  No?

Classroom status of Child/Youth:  Self-Contained  Inclusion  Resource Classes

Has Child/Youth been suspended:  Yes  No?

Placed in alternative program?  Yes  No Name: \_\_\_\_\_

Services provided by the school:  OT  PT  Speech  Assisted Technology  1:1 Aid Services

Behavior Specialist  Counseling  Autism Specialist  SCL  Special Ed Counseling

Other \_\_\_\_\_

**Agency Involvement**

Please list ALL PAST and PRESENT involvement with below agencies:

**Juvenile Justice Involvement (Past & Present)** Yes No PID # \_\_\_\_\_

Most Recent Contact Person/Phone#: \_\_\_\_\_

Disposition Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Court Status: Pending Court Deferred Prosecution On Probation On Parole C.O.P.E.

Other \_\_\_\_\_ Next Court Date: \_\_\_\_\_

History with Agency (List current & prior reason for referral w/ dates and outcomes):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child Protective Services Involvement (Past & Present)** Yes No

Most Recent Referral Date: \_\_\_\_\_ Most Recent Contact Person/Phone#: \_\_\_\_\_

History with Agency (List current & prior reason for referral w/ dates and outcomes):

\_\_\_\_\_  
\_\_\_\_\_

**ATCIC Involvement (Past & Present)** Yes No

Enrollment Date: \_\_\_\_\_ Most Recent Contact Person/Phone#: \_\_\_\_\_

Services Provided: Therapy Psychiatric/MEDS TACOMI Case Mgmt FPP

History with Agency (List current & prior reason for referral w/ dates and outcomes):

\_\_\_\_\_  
\_\_\_\_\_

**Travis Co. Health & Human Service Programs (Past & Present)** Yes No

Healthy Families Children F.I.R.S.T. TRIAD YFAC/CIS  Emergency Services (Food, Rent Asst)

Deaf Services  Neighborhood Conferences  Community Center: \_\_\_\_\_

**Other Counseling/Psychiatric Agencies or Programs (Past & Present)** Yes No

If yes please list agency(s) w/ dates of involvement: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please list ALL Community Resource(s) this family has utilized with dates of involvement.**  
(examples: Faith-based, Recreation Programs, Support Groups, Mentors, Coaches, Non-Profits, etc.)

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## Placement History of Child/Youth

### Residential Placement(s)/Hospitalization(s)

1. Facility \_\_\_\_\_ Admit Date \_\_\_\_\_ End Date \_\_\_\_\_  
Reason for Admission \_\_\_\_\_

Discharge Status:  Successful  Unsuccessful  Funding Constraints  Other \_\_\_\_\_

2. Facility \_\_\_\_\_ Admit Date \_\_\_\_\_ End Date \_\_\_\_\_  
Reason for Admission \_\_\_\_\_

Discharge Status:  Successful  Unsuccessful  Funding Constraints  Other \_\_\_\_\_

3. Facility \_\_\_\_\_ Admit Date \_\_\_\_\_ End Date \_\_\_\_\_  
Reason for Admission \_\_\_\_\_

Discharge Status:  Successful  Unsuccessful  Funding Constraints  Other \_\_\_\_\_

4. Facility \_\_\_\_\_ Admit Date \_\_\_\_\_ End Date \_\_\_\_\_  
Reason for Admission \_\_\_\_\_

Discharge Status:  Successful  Unsuccessful  Funding Constraints  Other \_\_\_\_\_

### Other (i.e. ICFMR, non-profit placement, relative placement, shelter):

1. Agency/Person Name \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
Type of Service \_\_\_\_\_ Outcome \_\_\_\_\_

2. Agency/Person Name \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
Type of Service \_\_\_\_\_ Outcome \_\_\_\_\_

3. Agency/Person Name \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
Type of Service \_\_\_\_\_ Outcome \_\_\_\_\_

4. Agency/Person Name \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
Type of Service \_\_\_\_\_ Outcome \_\_\_\_\_