 INTERCEPT HEALTH  
**Therapeutic Day Treatment  
Referral Form**

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| **Identifying Information** | | | | | | |
| Referral Date: | | | | | Parent Contacted: | |
| Client: | | | | | Date of Birth: | SSN: |
| Phone: | Gender: | | | | Race: | Marital Status: S |
| Client Address: | | | | | | |
| Parent/Guardian: | | | | Phone: | | |
| Current Address: | | | | | | |
| School: | Grade: | | | Special Education: | | |
| Probation/Parole Officer: | | | | DSS Case Worker: | | |
| Primary Physician: | | | | Other Professionals Involved: | | |
| Psychiatrist: | | | | | | |
| Medication/ Dosage: | | | | | | |
| **Medicaid Information** | | | | | | |
| Medicaid Recipient # (12 digit): | | | Recipient Eligible:  Eligible Yes  End Date: | | | |
| **Clinical Screening** | | | | | | |
| \_\_\_\_Danger to Self/Others (Explain below) | | \_ \_ Hospitalization Hx  - #\_\_\_ | | | | \_\_\_Legal Involvement |
| \_\_\_\_ Physical Aggression | | \_\_\_\_Outpatient Tx | | | | \_\_\_\_Runaway Potential |
| \_\_\_ Sexually Inappropriate | | \_\_\_\_Suicide Attempts - #\_\_\_ | | | | \_\_\_\_Chronic Medical Problems - Child |
| \_\_\_ Peer-Relationship Problems | | \_\_ Child Substance Abuse | | | | \_\_\_ Victim Physical/Emotional Abuse |
| \_\_\_\_Parent-Child Problems | | \_\_\_\_Eating/Sleeping Disturbance | | | | \_\_\_ Victim Sexual Abuse/Molestation |
| \_\_\_ School Failure/Behavior Problems | | \_\_\_ Anxiety/Phobias | | | | \_\_\_\_Death/Loss Issues |
| \_ Truancy/Drop Out/Expulsion | | \_\_\_ Sadness/Depression | | | | \_\_\_ Foster Placement |

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| Reason for Referral: |
| **Referral Source Name**: **Referral Source E-Mail:** |

|  |  |  |  |
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| **If available, please provide:** | | | |
| (   ) Social History | (   ) Current Psychological | (   ) Legal History | (   ) Current Physical Exam |

Pre-screen Completed By: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_  
  
IH Clinical Supervisor/Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_