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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_