

REFERRAL FORM

Phone: 614-824-KIDS (5437)

Fax: 614-252-8468

Email: intake@svfc.org

<p>CLIENT INFORMATION</p> <p>Client Name: _____</p> <p>FCCS Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Parent/Guardian Name: _____</p> <p>Client Address: _____</p> <p>City State Zip _____</p> <p>Home Phone: _____</p> <p>Work Phone: _____</p> <p>Cell Phone: _____</p> <p>Date of Birth: _____</p> <p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Social Security Number: _____</p> <p>Primary Language: _____</p> <p>Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes <input type="checkbox"/> ASL <input type="checkbox"/> Spanish <input type="checkbox"/> Other(specify): _____</p> <p><input type="checkbox"/> Medicaid Billing #: _____</p> <p><input type="checkbox"/> Caresource (MMIS #): _____</p> <p><input type="checkbox"/> Molina (Identification #): _____</p> <p><input type="checkbox"/> Private Insurance: _____</p> <p>Insurance Plan #: _____</p> <p>Group #: _____</p> <p>Insurance Member ID #: _____</p> <p>Current School: _____</p> <p>IEP: _____</p> <p>IQ (Full Scale IQ must be above 70): _____</p>	<p>REFERRING AGENCY INFORMATION:</p> <p>Agency Name: _____</p> <p>Worker Name: _____</p> <p>Address: _____</p> <p>City State Zip _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email: _____</p> <p>Requesting Type of Service (mark all that apply):</p> <p><input type="checkbox"/> Community Psychiatric Support Treatment (CPST)</p> <p><input type="checkbox"/> Intensive Home-Based Services</p> <p><input type="checkbox"/> Outpatient Family Counseling</p> <p><input type="checkbox"/> Therapeutic Preschool Program (must be fully potty-trained)</p> <p><input type="checkbox"/> Parent-Child Interaction Therapy (PCIT)</p> <p><input type="checkbox"/> Therapeutic School-Aged Program</p> <p><input type="checkbox"/> Therapeutic After-School Program</p> <p><input type="checkbox"/> Hispanic/Latino Services</p> <p><input type="checkbox"/> Deaf Services</p> <p><input type="checkbox"/> Pharmacological Management</p> <p><input type="checkbox"/> Residential Services</p> <ul style="list-style-type: none"> • Our center does not provide treatment for alcohol and/or substance abuse. Please have client contact their insurance company for available treatment options for these disorders
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Presenting Issues (mark all that apply):

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| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Depression | <input type="checkbox"/> Inappropriate Sexual Behavior |
| <input type="checkbox"/> Anger Issues | <input type="checkbox"/> Disruptive Behaviors | <input type="checkbox"/> Self Abuse or Mutilation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emotional Outbursts | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Argumentative or Uncooperative | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Social Isolation or Withdrawal |
| <input type="checkbox"/> Danger to self or others | <input type="checkbox"/> Homicidal Ideation | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Other: _____ |

Authorization: I authorize the referring agency/worker above to refer my child for mental health services to St. Vincent Family Center for the reasons stated. Also, so that they may coordinate care and treatment for my child, I give my permission for the referring agency/worker and mental health professional to communicate about the needs and courses of action with respect to my child. I understand that I may revoke this permission at any time either in person or in writing.

Parent/Guardian Signature

Date