2250 S. Oneida, Ste. 200, Denver, CO 80224 | T: (303) 433-1975 F: (303) 433-1980
1728 Topaz Drive, Loveland, CO 80537

Referral for Therapeutic Services

Client Name: **Referral Date:**
DOB: **Referring Source:**
Birth Gender:

Funding *(authorization must be completed prior to start date)*

Referred by: (please include name, title, phone, fax, address, & email)		
What is funding source? *(please check all that apply)* If there is commercial insurance please add that info as well.		
Medicaid # (if Applicable)		
Service authorization # (if Applicable)		
Name of Mental Health Privilege Holder/Decision Making Authority- . (NOT THE CASE WORKER)		
	Name	
	Address	
	phone number & email	
	Relevant custody arrangements:	

Services being requested (weekly):

Number of Psychiatric Hospitalizations

Reason for Referral:

Family Information

Relationship	Name/s		Address (including Zip)	Contact
Birth Parent(s)				Phone: Email:
Foster Parent Information (if Applicable)				Phone: Email:
Other siblings or children in home	Name/s	Age		

Please provide information about environmental or health issues we should be aware of

Legal Involvement-Type of charge/adjudication

Mental Health Diagnosis

DSM **V** Code	Diagnosis *(primary & secondary)*	Source of Diagnosis
F		
F		
F		

Collaborative Documentation (IEP, discharge summary, testing assessments, Treatment Plans etc)

Medication History

Start Date	End Date	Name of Medication & Dosage	Reason for Medication	Effective (Y or N)

Situation and/or Concerns:

*Please check the box under column "**C**" for current issue and "**H**" for historical issue that does not present a problem at this time. Otherwise, leave blank.*

C H

Legal Involvement
- ☐ ☐ Charges Filed
- ☐ ☐ Charges Dropped
- ☐ ☐ Adjudicated
- ☐ ☐ On Probation

If legal involvement-see below

Self-harm Behaviors
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Drug Use
- ☐ ☐ Cutting/Self Mutilating
- ☐ ☐ Head-banging
- ☐ ☐ Eating Disorder
- ☐ ☐ Poor Body Image
- ☐ ☐ Unprotected Sex
- ☐ ☐ Multiple Sex Partners
- ☐ ☐ Sexualized Behaviors
- ☐ ☐ High-risk Activities
- ☐ ☐ Running Away
- ☐ ☐ Suicide Attempt/Idea

Harm to Others
- ☐ ☐ Homicidal Attempt/Idea
- ☐ ☐ Fire Setting
- ☐ ☐ Property Destruction
- ☐ ☐ Stealing
- ☐ ☐ Animal Cruelty
- ☐ ☐ Sexual Aggression
- ☐ ☐ Physical Aggression
- ☐ ☐ Verbal Aggression

C H

Academic
- ☐ ☐ Learning Disability
- ☐ ☐ In Contained Classroom
- ☐ ☐ Trouble paying attention
- ☐ ☐ Fighting w/Peers
- ☐ ☐ Fighting w/Teachers
- ☐ ☐ Suspension/Detention
- ☐ ☐ Work not getting done
- ☐ ☐ Truant

Social/Emotional Behaviors
- ☐ ☐ Argumentative
- ☐ ☐ Isolated/Withdrawn
- ☐ ☐ Temper Tantrums
- ☐ ☐ Swearing
- ☐ ☐ Lying
- ☐ ☐ Cheating
- ☐ ☐ Disagrees/Opposes
- ☐ ☐ Demanding/Hard to Please
- ☐ ☐ Likes to Control Outcomes
- ☐ ☐ Trouble Following Direction
- ☐ ☐ Impulsive
- ☐ ☐ Poor Problem-solving Skills
- ☐ ☐ Poor Hygiene
- ☐ ☐ No or Few Friends
- ☐ ☐ Gang Involvement
- ☐ ☐ Easily Influenced by Peers
- ☐ ☐ Poor Boundaries

C H

Mental Health
- ☐ ☐ Anxious
- ☐ ☐ Hypervigilant
- ☐ ☐ Depressed/Sad
- ☐ ☐ Disoriented/Confused
- ☐ ☐ Moody
- ☐ ☐ Obsessive/Compulsive
- ☐ ☐ Low Motivation
- ☐ ☐ Dissociative
- ☐ ☐ Paranoid
- ☐ ☐ Fearful
- ☐ ☐ Fantasy Thinking
- ☐ ☐ Grandiosity
- ☐ ☐ Nightmares
- ☐ ☐ Low-tolerance
- ☐ ☐ Hallucinations
- ☐ ☐ Tics/Repetitive Movement

Physical Health
- ☐ ☐ Chronic Illness or Pain
- ☐ ☐ Sleep Disturbance
- ☐ ☐ Hyperactive
- ☐ ☐ Fatigued/Tired
- ☐ ☐ Bedwetting
- ☐ ☐ Enuretic/Encopretic
- ☐ ☐ Weight (under or over)
- ☐ ☐ Failure to Thrive
- ☐ ☐ Pregnant

Other

☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____

Name of referring party: .

Name Date

Relationship:

Signature of individual(s) who hold therapeutic privilege if different from above:

Name Date