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Referral Information

Today's Date:

Patient Name:

Nickname:

Date of Birth:

Age:

Gender:

Person completing the form:

Relationship to Patient:

Who referred this patient to this clinic:

Reasons for referral:

Mental Health History

Has the patient received mental health treatment? YES NO
If yes, please elaborate below!

When	Provider Name	Reasons for Treatment	Diagnoses	Progress none, poor, fair, good, excellent

Has the patient received a psychological evaluation? NO YES

Date(s) of evaluation:

Has the patient had psychiatric hospitalizations? YES NO
If yes, please elaborate below!

Hospital:

Reason:

When/How long:

Suicide attempts YES NO

Method:

When:

History of self-harm YES NO

Most recent incident:

Substance Use History

History of nicotine use YES NO

Details:

History of recreational drug use YES NO

History of alcohol abuse YES NO

Received treatment For substance abuse: YES NO

Current substance use (including nicotine) YES NO

Substance:

Amount:

Frequency:

Date of last use:

Current caffeine use YES NO

Details:

Medical Information

Primary Care Physician (PCP):

Can we share information with your PCP: YES NO

Date of last physical:

Date of last labwork:

<u>If applicable, please briefly describe any experiences with the following:</u>

Hospitalizations, surgeries, emergency room visits:

Past medical conditions:

Current medical diagnoses:
(including problems with vision/hearing)

History of brain injury/neurological evaluation:

Sexual/menstrual/developmental concerns:

Current Medication(s)	Dosage	Purpose	How long? (Months)	Prescriber

Allergies:	Drug Allergies:
Pharmacy:	Address of pharmacy:

Please briefly describe any experiences with the following:

Family history of mental health concerns or treatment:

Family history of substance use/abuse:

Family history of suicide attempts or completions:

Any other significant family medical history:

Is there a family history of early death due to cardiac arrhythmia or conduction defect or other related cardiac issues? YES NO

If applicable, please answer the following regarding prenatal/developmental information:

Question	Response	Details
Exposure to drugs, alcohol, tobacco or prescription medication during pregnancy	YES NO UNSURE	Details:
Did you/your doctor note any pregnancy complications?	YES NO UNSURE	Details:
Did you/your doctor note any problems with delivery?	YES NO UNSURE	Details:
Birth weight:	Length of pregnancy	Full-term Premature
Did the patient have any complications after birth?	YES NO UNSURE	Details:

Indicate when the patient achieved the following activities:

(whether it was **N**ormal or **D**elayed)

Activity		
Crawled (avg 9 mos)	N	D
Spoke Words (avg 10 mos)	N	D
Walked (avg 12-18 mos)	N	D
Toilet Trained (avg 2-3 yrs)	N	D

Lifestyle Information

Does the patient have a legal history or offender issues?	YES NO UNSURE	Details:
Does the patient have a history of neglect?	YES NO UNSURE	Details:

Does the patient have a history of abuse? NONE PHYSICAL EMOTIONAL SEXUAL

Please indicate if the patient has experienced any of the following events:

- ○ Divorce of caregivers
- ○ Death of family member or significant person
- ○ Exposure to violence, drugs, or sexually explicit material
- ○ Significant move
- ○ Significant accident, illness, or injury
- ○ Other ____________________

Family spiritual beliefs/orientation:

Cultural/Ethnic Issues:

Caregiver Information (If Applicable)

Parents are: ○ Married ○ Engaged ○ Separated ○ Divorced ○ Never Married

Parent/Caregiver Name (1) : ○ Biological ○ Step ○ Adoptive ○ Foster/Guardian

Place of Employment: Occupation:

Parent/Caregiver Name (1) : ○ Biological ○ Step ○ Adoptive ○ Foster/Guardian

Place of Employment: Occupation:

Nicotine use in the household YES NO Details:

Family Information

Others living in the patient's home (siblings, grandparents, etc.)	Age	Gender	Relationship to patient

Other support systems? (grandparents, non-custodial parent/stepparent, etc.)	How often?	Relationship to patient

Demographic and Education Information (If Applicable)

Marital Status:	○ Single, Never Married	○ Partnered	○ Married	○ Divorced	○ Separated	○ Widow/er

Education:	○ Less than High School	○ High School or GED	○ Some College	○ 2-year degree	○ 4-year degree	○ Graduate degree

Current grade level:
(if summer, grade child will be entering)

School name:

Has the patient been suspended, expelled, or retained a grade? YES NO

Details:

Has the patient received early intervention or special education Services? YES NO

If yes, please list verification:

Other details:

Most recent IQ or educational assessment:

Extracurricular activities:

What is client's occupation:

FULL-TIME PART-TIME NOT EMPLOYED