Referral Form
Brewer-Porch Children's Center

Box 870156
University of Alabama
Tuscaloosa, AL 35487-0156

Phone (205) 348-7236
Fax (205) 348-9368
Email: brewerporch@ua.edu

PROGRAM TO WHICH REFERRAL IS BEING MADE:

Residential Programs:
- ☐ Intensive Residential Treatment Program
- ☐ Short Term Treatment and Evaluation Program
- ☐ Moderate Residential Program
- ☐ Therapeutic Foster Care

School/Outpatient Programs
- ☐ Outpatient Day Treatment Program
- ☐ Adolescent Adaptive Skills Training Program
- ☐ Community Autism Intervention Program

Date of Referral: _____ Insurance Provider: _____

Child's Full Name: _____
Last First Middle Nickname

Birthdate: _____ Age: _____ Grade: _____ Sex: _____ Race: _____

Social Security #: _____ Native Language Spoken at Home: _____

Legal Guardian: _____ Phone: H (____) _____ W (____) _____

Address: _____ Relationship: _____
Street City Zip

Parents: (☐ Same as Above)

Name(s): _____ Phone: H (____) _____ W (____) _____

Child Resides With: ☐ Parent ☐ Guardian ☐ Other: _____ Phone: (____) _____

REFERRAL/CLINICAL INFORMATION:

Check reason for referral to Brewer-Porch Children's Center:

- ( ) poor self-control
- ( ) cruelty to animals
- ( ) inappropriate aggressive behavior/hostile tantrums
- ( ) hyperactivity
- ( ) running away
- ( ) destructiveness
- ( ) poor school performance
- ( ) truancy
- ( ) oppositional/defiant
- ( ) manipulative behavior
- ( ) sexual acting out
- ( ) assaultive behavior
- ( ) other: _____

- ( ) physical abuse victim
- ( ) sexual abuse victim
- ( ) dysfunctional family relationships
- ( ) enuretic (☐ night ☐ day)
- ( ) encopretic
- ( ) withdrawn/regression/confusion
- ( ) moderate to severe depression
- ( ) moderate to severe anxiety
- ( ) homicidal ideation (☐ attempts)
- ( ) suicidal ideation (☐ attempts)
- ( ) poor social/interpersonal skills
- ( ) drug experimentation
- ( ) irrational fears
- ( ) _____

- ( ) low frustration tolerance
- ( ) inappropriate attention seeking behavior
- ( ) inadequate problem solving skills
- ( ) in need of 24 hour protective oversight and supervision in daily living
- ( ) impaired reality contact-(hallucinations, delusions, ideas of reference)
- ( ) disabling somatic symptoms
- ( ) medication compliance
- ( ) poor socialization skills
- ( ) inpatient care is not warranted
- ( ) _____

Explain checked items and include any recent precipitating events: _____

_____

_____

_____

_____

Has client ever received treatment from another mental health organization? ☐ Yes ☐ No
If yes, check type of service and provide details below. Age mental health treatment began? _____

☐ Outpatient/Counseling ☐ Outpatient/Psychiatric ☐ Case Management ☐ In-home intervention
☐ Day Treatment ☐ Residential ☐ Inpatient ☐ Emergency/After-Hours ☐ Other: _____

Dates	Type of Treatment	Agency and Address	Outcome/Diagnosis

Last Psychological Evaluation:
Date: _____
Provider: _____
IQ Score: _____

Diagnoses:
_____
_____
_____

Does the child exhibit developmental delay/disorder? ☐ Yes ☐ No If yes, check type:
☐ Intellectual Disability ☐ Autism ☐ Developmental Disorder/Delay: _____
If child has diagnosis of Autism, who made the diagnosis? _____ When? _____

What previous services and/or evaluations for Autism or other developmental delay/disorder has your child received? _____

Does your child have other areas of functioning you feel may need further evaluation (e.g., medication issues, educational needs not met)? _____

Juvenile Court Status (check if applicable):
☐ Dependent ☐ CHINS ☐ Pending custody action/petition _____
☐ Number of Arrests _____ ☐ Adjudicated/ ☐ Delinquent ☐ Probation Officer _____
Explain: _____

FAMILY INFORMATION:

Is the family aware of their child's difficulties? ☐ Yes ☐ No

Were family members informed/involved with this referral? ☐ Yes ☐ No Date Discussed: _____

To what degree do you think the family will participate regarding evaluation/treatment of their child? Why?

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List information regarding people living in client's current home:

Name	Relationship	Age	Name	Relationship	Age

Household Income: _____ Child Receives SSI? ☐ No ☐ Yes: $_____ / month

List additional family members or significant others with whom client has contact:

Name	Relationship	Age	Name	Relationship	Age

EDUCATION INFORMATION:

Current School: _____ Teacher: _____ Grade:_____

Address: _____ Phone: _____

If not in school please give reason and last school attended: _____

_____

Is child ☐ General Ed ☐ Special Ed ☐ 504 ☐ N/A ☐Unknown

Date Special Ed/504 services began:_____ Date of Last IEP/504:_____

If Special Ed/504, check applicable: ☐MR ☐ED ☐LD ☐DD ☐OHI ☐ Unknown ☐Other:_____

Classroom Placement: ☐Regular ☐ Monitoring ☐ Resource ☐Self Contained ☐ Unknown

Academic Functioning:	On Grade Level	Below Grade	Above Grade	Comments:
Reading	☐	☐	☐	_____
Math	☐	☐	☐	_____
Spelling	☐	☐	☐	_____

Alternative school placements? ☐ Yes ☐ No If Yes, Explain: _____

_____

Previous Schools: _____

_____

Any Grades Repeated? ☐No ☐Yes If yes, which grade(s): _____

Reason: _____

Any Disciplinary Action/Suspensions/Expulsions? Explain: _____

_____

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MEDICAL INFORMATION (Please include copy of last physical. Physical with last year required for Residential Programs):

Medicaid: ☐ Yes ☐ No Medicaid #: _____

All-Kids: ☐ Yes ☐ No All-Kids #: _____

Other Medical Insurance: ☐ Yes ☐ No Name as appears on card:_____

Insurance Company:_____ Policy #:_____ Group #:_____

For Residential Programs:

Date of Last Physical: _____ Date of Last TB test: _____

Last Dental Exam: _____ Last Eye Exam: _____

Height. _____ Eye Color _____

Weight. _____ Hair Color _____

Allergies:

☐ No Known Allergies (NKA)
☐ Medications _____
☐ Food _____
☐ Other _____

Developmental History

Birth Wt. _____
Delivery: ☐ Normal ☐ Problems _____

Child was born: ☐ Full Term ☐ Early: #of weeks_____ ☐ Late : # of weeks_____

Condition at birth: ☐ Normal ☐ Jaundice ☐ Injury, describe:_____
☐ Other:_____

Milestones (Record Approximate Age):

Sat alone _____ Spoke in Sentences _____
Walked alone _____ Toilet Trained _____
Said Words _____ Dressed Self _____

Difficulties in toilet training: ☐ Yes ☐ No
If yes, describe:_____

Current : Enuresis: Daytime ☐ Yes ☐ No
: Encopresis: Daytime ☐ Yes ☐ No

If yes, describe:_____

Medical History:

	Age		Age		Age
☐ Measles	_____	☐ Birth Defects	_____	☐ Broken Bones	_____
☐ Mumps	_____	☐ Meningitis	_____	☐ Anemia	_____
☐ Chicken Pox	_____	☐ Lead Poisoning	_____	☐ Head Injury	_____
☐ Whooping Cough	_____	☐ Ingested Poison	_____	☐ Brain Damage	_____
☐ Asthma	_____	☐ Headache	_____	☐ Ear Infections	_____
☐ Short of Breath	_____	☐ Dizziness/Fainting	_____	☐ High Fever	_____
☐ Pneumonia	_____	☐ Clumsiness	_____	☐ Tonsillitis	_____
☐ Kidney Problems	_____	☐ Heart Palpitations	_____	☐ Seizures	_____
☐ Eye Problems	_____	☐ Chest Pain	_____	☐ Skin Problem	_____
☐ Hearing Problems	_____	☐ Heart Murmur	_____	☐ Diabetes	_____
☐ Speech Problems	_____	☐ GI Problems	_____	☐ Other: Explain below	

Comments: Explain any checked boxes:_____

_____

_____

_____

Current Medical Problems:

☐ No
☐ Yes Describe: _____

_____

_____

_____

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Sleep Pattern:	
# of hours: _____ Bedtime: _____	Sleep Difficulty: ☐ Yes ☐ No If yes, mark the following: ☐ Difficulty falling asleep ☐ Awakens early ☐ Awakens frequently ☐ Sleep aids ☐ Other _____

Hospitalizations/Surgeries:

Name of Hospital Date Admitted Doctor Reason for Admission

1. _____ ☐ Psychiatric ☐ Medical

Describe: _____

2. _____ ☐ Psychiatric ☐ Medical

Describe: _____

3. _____ ☐ Psychiatric ☐ Medical

Describe: _____

Immunizations:

Up to Date: ☐ Yes ☐ No

Date of Last Tetanus: Month _____ Year _____

Please Send a Copy of Immunization Record (Blue Card) with Referral Information

Current Medications (Prescription, Over the Counter, Inhalers, Supplements):

Name	Dose	Frequency	Indication	Last Dose	Prescribing Physician	Side Effects

Previous Psychotropic/Mental Health Medications:

Name	Dose	Frequency	Indication	Last Dose	Prescribing Physician	Side Effects

Client Substance Use History

☐ N/A

☐ Smoke Packs/Day _____ No. of Years _____

☐ Alcohol Type _____ Amount _____ No. of Years _____

☐ Drug Use Type _____ Amount _____ No. of Years _____

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Please list all medical problems and/or exceptionalities (language, speech, hearing, weight, allergies, size, appearance, physical limitations, etc): _____

_____

_____

Is there a need for an interpreter ☐ No ☐ Yes If yes explain _____

Primary Physician: _____ **Phone:**_____

Other Risk Factors: Please check which factors, if any, might place this child at increased risk if he/she required crisis intervention involving physical restraint or seclusion:

☐ History of abuse/trauma ☐ Medical condition ☐ Physical disabilities
☐ Cultural ☐ Language barrier

Please explain: _____

_____

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Basic Living Skills Identification

Child's Name: _____ Date: _____

Name of person(s) completing the form: _____ Relationship to Child: _____

_____ _____

Please check areas in which the child needs basic living skills.

Personal Hygiene _____

- ☐ Child needs improvement with independently dressing/undressing
- ☐ Child needs improvement with toileting skills
- ☐ Child needs improvement with grooming skills (e.g., brushing teeth, bathing)
- ☐ Child needs improvement with personal cleanliness, e.g., hand washing
- ☐ Child needs improvement with complying with Code of Conduct dress code
- ☐ Other: _____

Meal Preparation _____

- ☐ Child needs to learn or improve table manners
- ☐ Child needs to learn how to plan and budget for a meal
- ☐ Child needs to learn how to prepare basic meals safely and appropriately
- ☐ Child needs to learn to make appropriate menu choices
- ☐ Child needs to learn to set and/or clear the table correctly
- ☐ Other: _____

Housekeeping/Tidiness_____

- ☐ Child needs improvement with laundry skills
- ☐ Child needs improvement with keeping things neat at home (e.g., making beds, picking up clothing).
- ☐ Child needs improvement keeping things clean (e.g., cleaning toilet)
- ☐ Child needs improvement with keeping work area straight
- ☐ Other: _____

Healthy Lifestyle _____

- ☐ Child needs improvement in the area of nutrition
- ☐ Child needs improvement in his/her fitness level
- ☐ Child needs improvement in competitive and non-competitive recreation
- ☐ Child needs improvement in the area of sexual education
- ☐ Child needs improvement in the area of First Aide
- ☐ Child need improvement with knowledge of drug and alcohol issues (health and legal consequences)
- ☐ Other _____

Stress Management _____

- ☐ Child needs improvement in learning and using alternatives to tantrums and/or aggression when angered (e.g., instead of hitting, Child talks about feelings)
- ☐ Child needs improvement in learning and using appropriate ways of controlling anxiety or "nerves"
- ☐ Child needs improvement in not withdrawing from situations when they become stressful and/or difficult
- ☐ Child needs improvement with tolerating frustration and/or delaying gratification
- ☐ Child needs improvement with stopping and thinking before acting implusively
- ☐ Other: _____

Communication _____

- ☐ Child needs improvement in expressing his/her wants and needs appropriately
  - ☐ With peers
  - ☐ With adults
- ☐ Child needs improvement in understanding when others are speaking to him/her
  - ☐ With peers
  - ☐ With adults
- ☐ Child needs improvement expressing basic needs in written form

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- ☐ Child needs improvement reading and understanding simple communications (e.g., notes, signs, directions, reading a menu)
- ☐ Other _____

Social Skills _____

- ☐ Child needs improvement initiating positive interactions
  - ☐ With peers
  - ☐ With adults
- ☐ Child needs improvement responding when others try to interact with him/her
- ☐ Child needs improvement making appropriate eye contact with others
- ☐ Child needs improvement getting along with others
  - ☐ With peers
  - ☐ With adults
- ☐ Child needs improvement recognizing and/or understanding his/her feelings
- ☐ Child needs improvement recognizing and/or understanding feeling of others
  - ☐ With peers
  - ☐ With adults
- ☐ Child needs improvement behaving appropriately given the social situation (e.g., not speaking loudly in church)
- ☐ Other _____

Community Awareness _____

- ☐ Child needs help in understanding how to be a responsible citizen
- ☐ Child needs help understanding community rules and laws
- ☐ Child needs help understanding when a situation is dangerous and what to do in those situations (e.g., strangers, bad weather)
- ☐ Child needs improvement identifying community recreational and leisure resources
- ☐ Child needs help understanding community services available and how to access them
- ☐ Child needs improvement with identifying job opportunities and employment possibilities in the community
- ☐ Other _____

Medication Management _____

- ☐ Child needs improvement learning to take medication, and understanding the benefits and side effects of medication
- ☐ Child needs to learn to visually recognize prescribed medication
- ☐ Child needs improvement identifying effects of medications on themselves
- ☐ Child needs improvement identifying frequency, time, and dosage of own medications
- ☐ Child needs improvement with self-administration of meds
- ☐ Other _____

Money Management _____

- ☐ Child needs improvement in recognizing coins and paper money and the function of money
- ☐ Child needs improvement in understanding basic math skills involved in counting change and making purchases
- ☐ Child needs improvement in planning and saving for a particular purpose (i.e., budgeting)
- ☐ Other _____

Patient Education/re: Symptoms _____

- ☐ Child needs improvement with identifying own symptoms and behavior problems
- ☐ Child needs improvement in understanding how his/her behaviors/symptoms affect themselves
- ☐ Child needs improvement in how to cope effectively with behaviors/symptoms
- ☐ Other _____

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Referral Agency:

☐ Department of Human Resources, County:_____

☐ School System: _____ ☐ Community Mental Health Center:_____

☐ Other:_____

DHR Referrals Only:

Case #:_____ Last ISP: _____ ISP Permanency Goal: _____

Termination of Parental Rights: ☐ Completed ☐ Planned ☐ Not Applicable

DHR Caseworker: _____ Phone: _____

Can contact via email: ☐ No ☐ Yes If Yes, Email address: _____

DHR Supervisor: _____ Phone: _____

Guardian Ad Litem: _____ Phone: _____

COMPLETE FOR ALL REFERRALS:

_____ _____ _____
Signature of person completing the form | Position / Relationship | Date

_____ _____
Printed Name | Phone Number

TO EXPEDITE REFERRAL:

Attach copies of cumulative records/transcripts, report cards/grades, attendance records, special test/counseling reports, psychological testing, contacts with school authorities, IEP, social summaries, etc. (if applicable)

Please include or attach any other comments, material, or information that may assist us in understanding and helping this child.

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For BPCC Use Only

Date Referral Form Received at BPCC:_____ BPCC Case #_____

Educational Materials	Medical Information	Miscellaneous
☐ Report Card	☐ Physical Exam	☐ Birth Certificate
☐ IQ Test Results	☐ Insurance Information	☐ Psychosocial Summary
☐ Academic Testing Results	☐ Psychiatric Reports	☐ Psychological Evaluation
☐ IEP	☐ Immunization Records	☐ Social Security Card
		☐ Medicaid Card
_____	_____	_____

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