Referral Form

Brewer-Porch Children's Center

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University of Alabama
Tuscaloosa, AL 35487-0156

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PROGRAM TO WHICH REFERRAL IS BEING MADE:

Residential Programs:

- ☐ Intensive Residential Treatment Program
- ☐ Short Term Treatment and Evaluation Program
- ☐ Moderate Residential Program

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

( ) 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( ) withdrawn/regression/confusion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
( ) inpatient care is not warranted
( ) other: ________________________
( ) other: ________________________
( ) other: ________________________

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?
____

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: ____
____
____
____

Sleep Pattern:		
# of hours: ___________ Bedtime: ___________	Sleep Difficulty: If yes, mark the following:	☐ Yes ☐ No ☐ 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 __________

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: ____

____

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 EDUCATION/SCHOOL BASED REFERRALS:

____________________________	________________________	_________________________
Key/Lead Teacher Printed Name	Name of School	Phone Number
____________________________	________________________	_________________________
Email Address	Special Education Coord./Designee	Date Signed

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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