REFERRAL FORM

Services Requested:

☐ Residential Treatment ☐Group Home ☐Diversion/DAP ☐IOP-MH ☐IOP-SA ☐Respite ☐Partial Program

Client Information:

Name: _____ Date of Birth: _____

Gender: Male ☐ Female ☐ Race/Ethnicity _____

School & Grade: _____IEP in school? Yes ☐ No☐

Client's Current Placement: ☐Home ☐Group Home ☐Foster Home ☐Psychiatric Hospital

Please specify location (name of hospital or facility) _____

Parent or Legal Guardian Information:

Name of Parent/Legal Guardian: _____

Address: _____

Contact #'s: Home:_____Cell:_____Work: _____

Email:_____

Payment Information: (please complete all areas)

Type of Insurance: ☐Medicaid (AHCCCS) ☐Private Ins. ☐Private Pay Other: _____

Name of Insurance: _____Phone #: _____

Insurance ID:_____ Group # _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Address: _____

Referral Source Information: (Complete this section to enable us to contact you after the referral is made).

Name: _____ Agency: _____

Mailing Address: _____

E-mail:_____Phone#_____ Fax#_____

How did you hear about The New Foundation? _____

DSMD ICD-10 Diagnosis

_____

_____

_____

List Current Medications: Is adolescent Compliant with Medications? Yes ☐ No ☐

_____

_____

Reason for referral for treatment: Please describe specific behaviors your child is exhibiting including the frequency and severity of self-harm, physical aggression, high risk behaviors, legal involvement, and property damage in the past 30 days.

_____

_____

_____

_____

_____

_____

_____

Targeted Treatment Goals (what is the desired outcome of treatment)

_____

_____

_____

Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Hallucinations: _____	_____	_____	_____	_____	_____
Delusions:	_____	_____	_____	_____	_____
Aggression:	_____	_____	_____	_____	_____
Bizarre (psychotic behavior, describe below)	_____	_____	_____	_____	_____
Anxiety/Nervousness	_____	_____	_____	_____	_____
Obsessive/Compulsive	_____	_____	_____	_____	_____
Phobias/Fears	_____	_____	_____	_____	_____
Depressed Mood	_____	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____	_____
Sleep Disturbance	_____	_____	_____	_____	_____

Anger/Temper Tantrums	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Attention Deficit	_____	_____	_____	_____	_____

Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Elimination Problems	_____	_____	_____	_____	_____
Oppositional/defiant to those in authority	_____	_____	_____	_____	_____
Antisocial/delinquent behavior/ conduct disorder	_____	_____	_____	_____	_____
Over sexualized behavior	_____	_____	_____	_____	_____
Somatic complaints with no known medical cause	_____	_____	_____	_____	_____
Attachment disorder (explain below)	_____	_____	_____	_____	_____

Other (explain)

_____

_____

_____

_____

_____

Does the adolescent require substance abuse treatment? Yes ☐ No ☐

Types of substance and frequency of use: _____

_____

_____

Any questions regarding the referral process can be directed to: Admissions

480-945-3302 Ext: 125 or admissions@tnfaz.org

1200 North 77th Street, Scottsdale, Arizona, 85257
Phone: (480) 945-3302 / Fax: (480) 945-9308
Website: www.thenewfoundation.org