



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:

Shannon Dinning, LPC, Admissions Director

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

