REFERRAL FORM FOR

MENTAL HEALTH SERVICES

Client Information:

Name: _____ Date of Birth: _____ Race/Ethnicity: _____

Gender: ☐ Male ☐ Female School & Grade: _____

Services Requested: ☐ BHIF ☐ BHRF ☐ Diversion/Dap ☐ IOP-MH ☐ IOP-SA ☐ Respite ☐ PHP

Client's Current Placement: _____

Parent or Legal Guardian Information:

Name of Parent/Legal Guardian: _____

Address: _____

Contact #'s: Home: _____ Cell: _____ Work: _____

Type of Setting: ☐ Home ☐ Group Home ☐ Foster Home ☐ Psychiatric Hopsital Other: _____

Payment Information:

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

Name of Insurance: _____

Insurance ID: _____ Phone #: _____

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

Name: _____ Phone # _____

Mailing Address: _____

E-mail Address: _____

How did you hear about The New Foundation? _____

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	_____	_____	_____	_____	_____

Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Mood Swings	_____	_____	_____	_____	_____
Sleep Disturbance	_____	_____	_____	_____	_____
Irritability	_____	_____	_____	_____	_____
Anger/Temper Tantrums	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Attention Deficit	_____	_____	_____	_____	_____
Eating Problems	_____	_____	_____	_____	_____
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) _____

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors your child/adult is exhibiting:

_____

_____

_____

Additional Comments: _____

_____

_____

PLEASE SEE ATTACHED CHECKLIST NEEDED FOR PLACEMENT CONSIDERATION AT THE NEW FOUNDATION

Any questions regarding the referral process can be directed to:

Shannon Dinning, LPC, Admissions Director

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

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

DOCUMENTATION CHECKLIST FOR REFERRING AGENCIES (Pre-Admission)

To: _____ **Date:** _____

Re: _____ **DOB:** _____

The New Foundation's Admissions Department has recently received a referral for the above mentioned client, for possible placement in the _____ Program.

We would like to review clinical information regarding this client to determine if placement at our facility would be appropriate.

Below are documents that are required in order to ***review for placement.***

*PLEASE NOTE: The New Foundation **cannot accept any referral for admission** without the **required and completed** documentation listed in items 1 - 5 below.*

		Included	Not Applicable
1)	Comprehensive Assessment (Core Assessment) **MUST BE SIGNED BY BHP - Signature must also be within 30 days of the assessment.**	☐	☐
2)	Most recent annual update to the Comprehensive Assessment - **SIGNED AND DATED BY A BHP AND MUST BE LESS THAN A YEAR OLD.**	☐	☐
3)	Most recent CFT notes and CFT Service Plan. **MUST CONTAIN CLIENT, PARENT/GUARDIAN AND CASE MANAGER SIGNATURES.**	☐	☐
4)	Strengths, Needs and Culture Discovery.	☐	☐
5)	Out of Home Placement Package	☐	☐
	Other helpful supporting documentation:		
	Most recent psychiatric and medical evaluations:	☐	☐
	Current and past medical history.	☐	☐
	Last psychiatric notes (if applicable).	☐	☐
	I.E.P.	☐	☐

Please return this checklist with your documentation.

Thank you for your time and attention to this matter. After we receive these documents and review we will schedule an assessment to determine appropriateness in our program.

Please e-mail all documentation to admissions@thenewfoundation.org or fax to 480-945-9308 for the attention of the Director of Admissions.

Thank you.

Updated 07/01/2014