REFERRAL FORM

Please Note*: The New Foundation *CANNOT ACCEPT ANY REFERRAL FOR ADMISSION without completion of ALL the following required information and documentation

How did you hear about The New Foundation? _____

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

Client Information:

Name: _____

Date of Birth: _____ Race/Ethnicity: _____ Gender: ☐ Male ☐ Female

School & Grade: _____

Client's Current Placement: _____

Contact Name: _____ Contact Phone Number: _____

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

Court Ordered Treatment? ☐ Yes ☐ No

If Yes, JPO's Name and phone number _____

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

Name: _____

E-mail Address: _____

Phone Number: _____ Fax Number: _____

Parent or Legal Guardian Information:

Name of Parent/Legal Guardian: _____

Address: _____

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

DCS Involvement? ☐ Yes ☐ No

Caseworker Name: _____ Phone#: _____

Payment Information: **Please include copies of all insurance cards for billing.**

First Insurance Option:

Type of Insurance: ☐ Medicaid ☐ Private Ins. ☐ Self Pay Other: _____

Name of Insurance: _____

Insurance ID: _____ Phone #: _____

Policy Holder Name : _____ D.O.B: _____

Address: _____

Please add any additional 2nd insurance information along with a copy of all insurance cards for billing.

Second Insurance Option:

Type of Insurance: ☐ Medicaid ☐ Private Ins. ☐ Self Pay Other: _____

Name of Insurance: _____

Insurance ID: _____ Phone #: _____

Policy Holder Name : _____ D.O.B: _____

Address: _____

Primary Care Physician _____

Phone#: _____ Fax:_____

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	_____	_____	_____	_____	_____
Irritability	_____	_____	_____	_____	_____
Anger/Temper Tantrums	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Attention Deficit	_____	_____	_____	_____	_____
Eating Problems	_____	_____	_____	_____	_____
Elimination Problems	_____	_____	_____	_____	_____

Oppositional/defiant to those in authority	_____	_____	_____	_____	_____
Antisocial/delinquent behavior/ conduct disorder	_____	_____	_____	_____	_____
Somatic complaints with no known medical Cause	_____	_____	_____	_____	_____
Attachment disorder (explain below)	_____	_____	_____	_____	_____

Other: (Explain)

_____
_____
_____
_____

Reason for Treatment Referral: In your own words, describe the child in need for mental health services. Please describe specific behaviors your child is exhibiting:

_____
_____
_____

Medical Conditions:

_____
_____

Additional Comments: _____
_____
_____

PLEASE COMPLETE CHECKLIST ON NEXT PAGE.

DOCUMENTATION CHECKLIST
FOR REFERRING AGENCIES
(Pre-Admission)

*PLEASE NOTE: The New Foundation **cannot accept any referral for admission** without the below required and completed documentation for Admission Consideration*

Please Note: Items 6-10 to be filled out by referral agency ONLY.

		INCLUDED
1)	Release of Information Signed by Parent/Guardian **REQUIRED TO SCHEDULE ASSESSMENT**	_____
2)	I.E.P. _____ Yes _____ No **IF YES DOCUMENTATION MUST BE INCLUDED.**	_____
3)	Most recent psychiatric and medical evaluations	_____
4)	Last Psychiatric Notes (if applicable)	_____
5)	Current and past medical history	_____
6)	Comprehensive Assessment (Core Assessment) **MUST BE SIGNED BY BHP-WITHIN 30 DAYS OF ASSESSMENT**	_____
7)	Most recent annual update to the Comprehensive Assessment **MUST BE SIGNED/DATED BY BHP-MUST BE LESS THAN ONE YEAR OLD**	_____
8)	Most recent CFT notes and CFT Service Plan **MUST CONTAIN CLIENT, PARENT/GUARDIAN AND CASE MANAGER SIGNATURES**	_____
9)	Strengths, Needs and Culture Discovery	_____
10)	Primary Care Physician Information	_____

PLEASE INCLUDE ALL REQUIRED DOCUMENTATION FOR PLACEMENT CONSIDERATION

Any questions regarding the referral process can be directed to:
Referral Coordinator
480-945-3302 Ext: 125 or tnf_admissions@turnanewleaf.org

The New Foundation - 1200 North 77th Street - Scottsdale, AZ 85257
Phone: 480-945-3302 Fax: 480-945-9308 Attn: Referral Coordinator
www.thenewfoundation.org