



Child and Family Urgent Response Team
Web Referral Form
125 Chaffee Street
Uniontown, PA 15401

Lindsay Henderson
Phone: (724)438-5520 Fax: (724) 437-1875

IDENTIFYING INFORMATION			
Child's Name	Date of Birth/Age:	Gender:	Race:
Address:	Phone:	Social Security Number:	
	Insurance:	MA Number:	

REFERRAL INFORMATION			
Referral Source:	Contact Person:	Phone:	
Psychiatrist / Psychologist:		Phone:	

Current Mental Health Diagnosis	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

REASON FOR REFERRAL

FAMILY INFORMATION		
Legal Guardian(s) / Relationship:	Biological Mother:	Biological Father:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Others Living in Household <i>(Please include name, age, and relationship to child)</i>		Immediate Relatives NOT Living in Household <i>(Please include name, age, and relationship to child)</i>

Previous and Current Mental Health Treatment	Dates and Facility	Outcomes
<input type="checkbox"/> ICM/RC or Blended Case Management		
<input type="checkbox"/> Outpatient		
<input type="checkbox"/> Partial		
<input type="checkbox"/> BHRS (wraparound)		
<input type="checkbox"/> Family Based		
<input type="checkbox"/> Psychiatric Hospitalization		
<input type="checkbox"/> Residential Treatment Facility or CRR		
<input type="checkbox"/> Other		

CURRENT MEDICATION

Name	Dose	Frequency

Any medical concerns:

Any Allergies:

School District:

School Attended:

Is there an IEP in place: YES or NO

If Yes please state goals involved:

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages)
