

**NEW DIRECTIONS REFERRAL FORM**  
**125 CHAFFEE STREET**  
**UNIONTOWN, PA 15401**  
**(724) 434-5437**  
**FAX (724) 434-1014**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ .Social Security# \_\_\_\_\_

D.O.B \_\_\_\_\_ .Age: \_\_\_\_\_ .Current Grade \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Parents Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian/Guardians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency: \_\_\_\_\_

\_\_\_\_\_

Type of Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

School District: \_\_\_\_\_

Current Classroom: L.S: \_\_\_\_\_

E.S: \_\_\_\_\_

Regular: \_\_\_\_\_

Referred By: \_\_\_\_\_

Name of Company: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Presenting Problems:** (specific difficulties; interventions attempted)

**Personal and Social History:** (Family composition, family history of psychiatric and medical illness, current family stressors)

**History of Previous Treatment:** (Include Psychiatric Hospitalizations and other Mental Health agencies with dates involved)

**Date of last Psychiatric Evaluation:** \_\_\_\_\_ (Please attach a copy)

**Diagnosis:** Axis I. \_\_\_\_\_

Axis II. \_\_\_\_\_

Axis III. \_\_\_\_\_

Axis IV. \_\_\_\_\_

**GAF** \_\_\_\_\_

**Current Medications:** (attach DUP if available)

**Any Medical Problems or Conditions in the Past?** (If yes please explain)

**Current Medical Conditions that is being treated regularly?** (if so, what? Please include any allergies)

**Other agencies involved:**    \_\_\_ Cys \_\_\_\_\_  
  \_\_\_ JPO \_\_\_\_\_  
  \_\_\_ Hope \_\_\_\_\_  
  \_\_\_ Other \_\_\_\_\_

**Any other information about the client for admission considerations:**

