Web Outpatient Referral Form – Children

Potential Client Information Fax form to 724-439-2667

Last Name____________________ First Name___________________________________
Date of Birth _____________Age ______ Sex ___ S.S. # _______________________
Address ____ _________
Phone ______________ Additional Number _____________Can a Message be left? Y/N
Parent/Guardian____ Biological/Foster
School____________________________ Grade_______ Special Ed or Life Skills Y N

Insurance _________________ ID # ______________ Group# _________________
Second Insurance___________ ID#________________ Group #__________________

Why are you seeking Outpatient Treatment now? What would you most like help with?:
____
____
____
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Previous Treatment History (include Inpatient and Op Dates)
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Suicidal/Homicidal Thoughts please call 724-437-1003
Self-Mutilating Behavior ***Y/N*** Auditory/Visual Hallucinations Y/N
Appetite ***Good/***Fair***/Poor*** Sleep Pattern ***Good/***Fair***/Poor***
Aggressive Behavior ***Y/N*** Destructive Behavior ***Y/N***
Thought process: Organized/***Disorganized***/Obsessive/***Other***_______________________
Mood: Stable/***Unstable***/Depressed/***Tearful***/Agitated/***Manic***/Other__________________
Behavior: Cooperative/***Uncooperative***/Aggressive/***Loud***/Quiet/***Other***________________

Current/Past Drug and Alcohol____
____
Current/Past Medical Problems:____
____
Current Medications:____
(dosages and who prescribes)
Services currently receiving:____
JPO? Y N ____________________ICM? Y N _____________________
Name of worker Name of worker
CYS? Y N __________________________
Name of worker