

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

PA Secure ID# _____
Date: _____

Name: _____ .Social Security# _____

D.O.B _____ .Age: _____ .Current Grade _____

Address: _____

Parent/Parents Name: _____ Phone: _____

Guardian/Guardians Name: _____ Phone: _____

(ATTACH GUARDIANSHIP/CUSTODY DOCUMENTS)

In case of emergency: _____

Type of
Insurance: _____

Policy # _____ Group# _____

Name of Policy Holder: _____

School District: _____ Home School: _____

Current Classroom: L.S: _____ ES: _____ Reg: _____

Itinerant: _____ Supplemental: _____ Full Time: _____

Related Services: Speech: _____ OT: _____ PT: _____

Referred By: _____

Name of Company: _____

Telephone: _____

Name of Person Completing Form: _____

Telephone of Person Completing Form: _____

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: _____ (MUST 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: