



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

DATE: _____

NAME: _____ **SSN:** _____

DOB: _____ **AGE:** _____ **CURRENT GRADE:** _____

PARENT(S) NAME: _____ **PHONE #:** _____

GUARDIAN(S) NAME: _____ **PHONE #:** _____

IN CASE OF EMERGENCY: _____

TYPE OF INSURANCE: _____

POLICY #: _____ **GROUP #:** _____

NAME OF POLICY HOLDER: _____

SCHOOL DISTRICT: _____

CURRENT CLASSROOM: **LS:** _____

ES: _____

REGULAR: _____

REFERRED BY: _____

NAME OF COMPANY: _____

PHONE #: _____

NAME: _____ **SSN:** _____ **DATE:** _____

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: _____

NAME: _____ **SSN:** _____ **DATE:** _____

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:
