NEW DIRECTIONS REFERRAL FORM

125 CHAFFEE STREET
UNIONTOWN, PA 15401
(724) 434-5437
FAX (724) 434-1014

Date: ______________
Client ID#: ______________
PA SECURE ID#: ________

PERSONAL INFORMATION

Name: __________________________________

D.O.B: ___________________ Age: ____________ Current Grade: _____________________

Address: ____

Parent/Parents Name: __________________________________ Phone: __________________

Guardian/Guardians Name: _____________________________ Phone :__________________

INSURANCE

Type of Insurance: ____

Policy #______________________________Group #_____________________________

Name of Policy Holder: ____

SCHOOL INFORMATION

School District: _______________________ Home School: _______________________

Current Classroom: Special Ed: ______________ Regular______________

Related Services: Speech: ___________OT_______________PT: ________________

REFERRAL INFORMATION

Referred By: _______ Parent _______ Guardian ______ Another agency

Telephone: ____

Referred Prescribers Name: ____

NPI#: ________________________ MA. Promise #: _________________________

Name of Person Completing Form: ____

Name: ______________________________ DOB: _______ Date: ________

Reasons for making referral at present - (specific reasons/recent incident)

Observed Behaviors (Choose all that apply)

Aggression	☐ Verbal	☐ Physical	☐ Property Destruction
Social deviance	☐ Run-away	☐ inappropriate in social media	☐ Sexually inappropriate
Peer conflict	☐ Bullying	☐ Poor peer interactions	☐ Argues for everything
Conduct	☐ ISS/OSS	☐ Truancy	☐ Disruptive
Legal	☐ Probation	☐ Pending charges	☐ House arrest
Substance Abuse	☐ Nicotine	☐ Alcohol	☐ Drugs
Defiant	☐ Spiteful	☐ Temper tantrums	☐ Blames others
ADHD	☐ Inattentive/ Distracted	☐ Impulsive	☐ Talks excessively/ Fidgety
Learning	☐ Reading issues	☐ Writing issues	☐ Math issues

Subjective Symptoms (Choose all that apply)

Anxiety	☐ Panic attack	☐ School avoidance	☐ Separation Anxiety
Depression	☐ Withdrawn/ Isolated	☐ Diminished interest	☐ Feels guilt/worthless
Sleep	☐ Tired	☐ Sleep in class	☐ Refuse task

Stressors (Choose all that apply)

Social	☐ Family/ relationship with parents	☐ Economic	☐ Loss of loved ones
Trauma	☐ Physical	☐ Emotional/Neglect	☐ Sexual
Parent Participation	☐ Good	☐ Fair	☐ Poor

Name: ______________________________ DOB: _______ Date: ________

Current Treatment Team:

Provider	Phone number	Last visit date
Psychiatrist		
Therapist		
PCP		
Others		
# Hospitalizations		

Other Agencies Involved:

☐ CYS ☐ JPO ☐ Family Based ☐ Wrap-Around ☐ Other ________

Medical (Choose all that apply)

Somatic complaints	☐ Headache	☐ Stomach aches	☐ Others
Medical issues	☐ Diabetes	☐ Seizures	☐ Heart

Medications - Is patient adherent to meds? ☐ Yes ☐ No ☐ I don't know

Medications	Dosage	Timings	Prescriber

Suicidal behaviors ☐ Yes ☐ No - Specify dates & means______________________________

Homicidal behaviors ☐ Yes ☐ No - Specify dates & means______________________________

Access to firearms or weapons ☐ Yes ☐ No- If Yes, specify______________________________

Current safety status____________________________________

Forward copies of the following information

☐ Intake Assessment ☐ History/physical ☐ Other Pertinent Records

_______________________________ _______________________
Signature of the Referring Authority Name / Date