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

Date: _____

Client ID#: _____

PERSONAL INFORMATION PA SECURE ID#: _____

Name: _____ DOB: _____

Age: _____ Current Grade: _____

Address: _____

Parent(s) Name:_____ Phone: _____

Guardian(s) Name:_____ Phone: _____

INSURANCE

Name of Insurance: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____

SCHOOL INFORMATION

School District: _____ Home School: _____

Current Classroom: Special Education ☐ Regular Education ☐

Related Services: Speech ☐ OT ☐ PT ☐

REFERRAL INFORMATION

Referred By: Parent ☐ Guardian ☐ Another Agency ☐

Telephone: _____

Referred Prescriber's 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 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Depression:	☐Withdrawn/isolated	☐Diminished interest	☐Feels guilt/worthless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	☐Sleeps in class	☐Refuses tasks

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	Name	Phone#	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 Issues	☐Other
Medical Issues	☐Diabetes	☐Seizures	☐Heart

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

Medication	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