Community Care Resources, Inc.

Therapy & Assessment Programs

Referral

Thank you for your referral. We appreciate your trust in our agency and we will attempt to provide excellent services to you and your youth. Please complete our form and return it to our agency.

NOTE: Please submit a copy of BOTH sides of the insurance card

CLIENT INFORMATION

Child's Name:______________________________ Age:______ DOB:___________________ Identifies as: ☐ Male ☐ Female

Client Lives with: ____ Relationship:_______________________

Address: ____
Street Address *City* *ZIP Code*

Phone: ____________________________________ Email:____

School: ____ Grade:______________________________________

Medical Assistance #: ______________________________ ☐ Not Applicable

Parent/Guardian(s): ____

Address: ____
Street Address *City, State* *ZIP Code*

Phone: ____________________________________ Email:____

Parent/Guardian(s): ____

Address: ____
Street Address *City, State* *ZIP Code*

Phone: ____________________________________ Email:____

Placement History:

COUNTY INFORMATION

County/Agency:____________________ Phone:____________

Referring Worker: ____________ Email:____________

Supervisor: ____________ Email:____________

BILLING INFORMATION

☐ Insurance*: ____________ *Please submit a copy of **both sides** of the Insurance card
☐ MA (Badger Care)
☐ CCS - County:____________
☐ Financial agreement with client's parent/legal guardian
☐ Service pricing agreement with County/School

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____________ Phone:____________

PRESENTING ISSUES

Primary Concern: ____________

Secondary Concern: ____________

Other Concerns: ____________

Current Symptoms/Problems: *please check all that apply*

☐ Aches & Pains	☐ Elevated mood	☐ Irritable	☐ School problems
☐ Angry	☐ Fears	☐ Learning difficulties	☐ Self-harm
☐ Anxious	☐ Gang involvement	☐ Neglect victim	☐ Sex offending
☐ AODA	☐ Hears voices	☐ Panic attacks	☐ Sexual abuse survivor
☐ Appetite disruption	☐ Hopeless	☐ Paranoid	☐ Sexualized talk/behavior
☐ Avoids talking about problems	☐ Hyperactive	☐ Peer problems	☐ Shut down
☐ Bad dreams	☐ Hyper vigilance	☐ Physical abuse survivor	☐ Sleep difficulties
☐ Defiant	☐ Impaired concentration	☐ Physical Aggression	☐ Suicidal
☐ Depressed mood	☐ Impaired memory	☐ Police contact	☐ Traumatic play
☐ Domestic violence	☐ Impulsive	☐ Running away	☐ Verbal aggression
☐ Eating disorder	☐ Other:____________		

MENTAL HEALTH/TREATMENT

Diagnosis: ____________

Previous Therapy

Provider Name:____________ Phone:____________

Dates:____________ ☐ Individual ☐ Family ☐Group

Provider Name:____________ Phone:____________

Dates:____________ ☐ Individual ☐ Family ☐Group

Current Therapy

Provider Name:______________________________________ Phone:____________________

Dates:______________________________________ ☐ Individual ☐ Family ☐Group

Has child had any evaluations? *please check all that apply*

☐ Psychological Provider:________________________ Date:__________________

☐ Psychiatric Provider:________________________ Date:__________________

☐ Other: __________________ Provider:________________________ Date:__________________

Medical History

Significant Medical History: ☐ Yes ☐ No Please explain: ______________________________

Allergies: *(food, meds, environmental)* ☐ Yes ☐ No Please explain: ______________________________

Asthma: ☐ Yes ☐ No Please explain: ______________________________

Encopresis/Enuresis: ☐ Yes ☐ No Please explain: ______________________________

Head Injury: ☐ Yes ☐ No Please explain: ______________________________

Seizures: ☐ Yes ☐ No Please explain: ______________________________

Fetal Alcohol Syndrome: ☐ Yes ☐ No Please explain: ______________________________

Prenatal substance exposure: ☐ Yes ☐ No Please explain: ______________________________

Medications *(please list)*: ____ Dosage:__________________

____ Dosage:__________________

____ Dosage:__________________

____ Dosage:__________________

Prescribing Provider(s): ________________________________ Contact Number(s):______________________

________________________________ Contact Number(s):______________________

________________________________ Contact Number(s):______________________

________________________________ Contact Number(s):______________________

Additional Comments/Notes: