Youth Advocate Program
Referral for Outpatient Program

***Internal Use Only:** **Clinician:**_____ **Diagnosis:**_____

Admit Date:_____ **End Date:**_____

Date of Referral: _____ **Referred by:** _____ **Phone Number:** _____

PATIENT/GUARDIAN INFORMATION *Primary language of patient* _____ *Primary language of guardian* _____
Spanish Speaking Therapist Required ☐ Yes ☐ No

Name: _____DOB: _____Age: _____ Gender: _____

Address: _____City: _____Zip Code: _____

Medicaid #: _____ Social Security #: _____

Other Insurance Information: _____

Guardian name: _____ Relationship to patient: _____

Address: _____City: _____Zip Code: _____

Phone number(s): Home: _____ Cell: _____ Work: _____ Other: _____

*Guardian DOB:_____ *Guardian Social Security #:_____**Guardian E-mail: _____
*for Patient Accounting Purposes **for Satisfaction Survey

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Address: _____

EDUCATION

School: _____ Grade: _____ ☐ Spec Ed ☐ Reg Ed Teacher: _____

Contact Person/Title: _____ Phone: _____

MEDICAL HISTORY

Primary Care Physician: _____ Phone/Address: _____

Diagnosis: _____ Allergies: _____

Current Medications: _____

Pharmacy: _____Phone/Address: _____

REFERRAL REASONS & HISTORY OF PRESENTING PROBLEMS (check all that apply)

❒ Abuse victim	❒ Depression	❒ Anxiety	❒ Defiant/oppositional
❒ Sleep issues	❒ Conflicts with parent	❒ Autistic withdrawal	❒ Conflicts with peers/siblings
❒ Conflicts with parents	❒ Temper tantrums	❒ Parent education	❒ Inattention
❒ Hyperactivity	❒ Eating issues	❒ Running away	❒ Disruptive behavior
❒ Suicidal ideation	❒ Homicidal ideation	❒ Cognitive/dev. delays	❒ History of Trauma
❒ School Performance	❒ History of Self Harm	❒ Other	❒ Diagnosis

OTHER INFORMATION

Are any case management services or other mental health providers currently servicing child? ☐ No

_____

What strategies have been implemented to address the identified referral problems?

_____

Has the child ever been admitted to psychiatric hospital? ☐ No
If yes, when & where was the last admission, and for what reason?

_____

Has the child ever been evaluated by a screening (i.e. crisis) center? ☐ No
If yes, when was the last evaluation and for what reason?

_____

Was child ever in any YAP program? If so, check all that apply: ☐ IIC ☐ Outpatient ☐ Other
If currently attending YAP what is expected discharge date? _____

NOTES/Disposition

Intake Date/Time:	**Psychiatric Eval Date/Time:**
Assigned Clinician:	**Group Room:**

**** If you have concerns regarding this referral please contact intake coordinator and/or present at treatment team. ****

ST
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