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REFERRAL FORM

CLIENT INFORMATION

Name of client: _____

Date of birth: _____ Home Phone: _____

Home address: _____

PARENT (S)/ CAREGIVER

Name: _____ Relationship: _____

Email: _____ Phone: _____

Name: _____ Relationship: _____

Email: _____ Phone: _____

I give permission to Dr. Frank to email general client information. Initials _____

I give permission to Dr. Frank to leave me a voice mail message. Initials _____

I give permission to Dr. Frank to send me a text message. Initials _____

Please list a password that you will use to open emails from Dr. Frank. _____

SCHOOL / DAYCARE CENTER

Name: _____ Teacher's Name: _____

Grade: _____ Phone: _____

Address: _____

PEDIATRICIAN

Name: _____ Phone: _____

Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

CURRENT CONCERNS AND FUNCTIONING

Reason for referral: *(What do you hope to accomplish in therapy?)*

Check the concerns (if any) which apply to the client:

• Behavioral and emotional functioning

- | | | |
|--|--|--|
| <input type="checkbox"/> aggression | <input type="checkbox"/> oppositional | <input type="checkbox"/> sadness |
| <input type="checkbox"/> high activity level | <input type="checkbox"/> tantrums | <input type="checkbox"/> difficulty separating |
| <input type="checkbox"/> impulsivity | <input type="checkbox"/> non-compliant | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> stealing/lying | <input type="checkbox"/> cutting/self-injurious behavior | <input type="checkbox"/> sleep disturbance |
| <input type="checkbox"/> inattentive | <input type="checkbox"/> anxiety/fears | <input type="checkbox"/> eating disturbance |

Other / describe _____

• Developmental functioning

Suspected difficulties with:

- speech/language motor development pre-academic skills sensory processing

Other / describe _____

• Academic functioning

Suspected difficulties with: reading writing spelling mathematics

• Other concerns (*please describe*) _____

Has the child been previously evaluated?

(*please include copies of any previous evaluation*) Yes No

If yes:

Where _____

When _____

Family functioning (family in which the child resides)

Please list immediate family members and other people who are important to your child.

(*List additional family members on back*)

Name _____ Age _____ Relationship to child _____

Name _____ Age _____ Relationship to child _____

Name _____ Age _____ Relationship to child _____

Please list any strengths or weaknesses in familial relationships and general family functioning.

Please list any current family stressors or significant changes in the child's life.

Please describe child's attachment to the primary caregiver(s).

other caregivers? _____

How does the child tolerate separations from caregivers?

Social functioning

How does the child get along with peers? _____

Difficulties in the following areas:

playing communicating fighting physical verbal

Strengths – please list three

1) _____ 2) _____ 3) _____

CLIENT HISTORY

MEDICAL HISTORY

Please list any allergies, surgeries, chronic illnesses, hospitalizations, medications

BIRTH HISTORY

Born full term: yes no

Exposure to substances: yes no

Complications during pregnancy or delivery: yes no Medical problems at birth: yes no

Please describe any problems: _____

Adoption: Yes No age: _____

Circumstances: domestic foreign open adoption closed adoption

THERAPY/TREATMENT HISTORY

(please include treatment goals, dates of treatment, therapist, and treatment progress)

Psychotherapy: _____

Speech and language therapy: _____

Physical therapy: _____

Occupational therapy: _____

Tutoring: _____