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REFERRAL FORM

PART I: CLIENT INFORMATION

CLIENT:

Name: _____

Date of birth: _____

Phone: _____

Address: _____

PARENT(S)/CAREGIVER(S):

Name: _____ Relationship: _____

Email: _____ Phone: _____

Name: _____ Relationship: _____

Email: _____ Phone: _____

☐ I give Dr. Frank permission to email general client information.

☐ I give Dr. Frank permission to leave me a voicemail message.

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

SCHOOL/DAYCARE CENTER:

Name: _____ Teacher: _____

Grade: _____ Phone: _____

Address: _____

PEDIATRICIAN:

Name: _____ Phone: _____

Address: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship: _____

Address: _____

PART II: CURRENT CONCERNS AND FUNCTIONING

REASON FOR REFERRAL:

What do you hope to accomplish in therapy? _____

_____

_____

_____

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

• Behavioral and emotional functioning

☐ Aggression ☐ Oppositional ☐ Sadness

☐ High activity level ☐ Tantrums ☐ Difficulty separating

☐ Impulsivity ☐ Non-compliant ☐ Withdrawn

☐ Stealing/lying ☐ Cutting/self-injury ☐ Sleep disturbance

☐ Inattentive ☐ Anxiety/fears ☐ 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

☐ Other / Describe: _____

☐ Other / Describe: _____

Has the child been previously evaluated?

☐ Yes Where? _____

When? _____

(Please include copies of any previous evaluations)

☐ No

FAMILY FUNCTIONING: (family in which the child resides)

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

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

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):

Please describe child's attachment to the other caregiver(s):

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) _____

PART III: 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? ☐ Yes ☐ No Complications during delivery? ☐ Yes ☐ No

Medical problems at birth? ☐ Yes ☐ No

Please describe any problems:

Adoption?

☐ Yes Circumstances: ☐ Domestic ☐ Foreign ☐ Open ☐ Closed

Age at adoption: _____

☐ No

THERAPY/TREATMENT HISTORY:

Please include information such as treatment goals, dates of treatment, therapist, and treatment progress.

☐ Psychotherapy:

☐ Speech/language therapy:

☐ Physical therapy:

☐ Occupational therapy:

☐ Tutoring: