I&A

Home of Integrated Behavioral Health Referral Form

**Please send completed form to:** [**MHCappointments@NYFoundling.org**](mailto:MHCappointments@NYFoundling.org)

**If services are requested for multiple family members, please complete a separate referral form for each**

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| **Date of Referral:** | | | | | | |
| **CLIENT INFO** | | | | | | |
| Client Legal Name (*First & Last*):  Client Chosen Name (*if different than legal name*): | | | | | | |
| Client Phone Number & Email: | | | | | | |
| Address: | | | | | | |
| Insurance Carrier: | | | Insurance CIN Number: | | | |
| *Demographics* | | | | | | |
| D.O.B.: | | Sex Assigned at Birth: | | | Ethnicity/Race: | |
| School: | | Grade: | | | Primary Language: | |
| Pronouns: | |  | | |  | |
| **GUARDIAN INFO (18 & under)** | | | | | | |
| Legal Guardian Name:  Guardian Phone & Email:  Is guardian aware of youth’s identity?  Yes  No  Notes: | | | | | Relation to Client:  Primary Language: | |
| **REFERRAL SOURCE INFORMATION** | | | | | | |
| Referral Source Name: | | | | | | |
| Referral Source Phone & Email: | | | | | | |
| Referral Source Agency (*If NYF Internal agency, answer below):* | | | | | | |
| Program: | Primary IP: | | | Start Date: | | Anticipated End Date: |

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| **SERVICES REQUESTED** | | |
| Trauma-Focused Cognitive Behavioral Therapy (Children 5-17) | Cognitive Processing Therapy (Adults & Adolescents 16+) | Psychiatric Evaluation |
| Child Parent Psychotherapy (Children 0-5 with caregiver) | Identity & Acceptance (individual, family, consultation; youth ages 3-21 | Psychological/Psychoeducational Evaluation (Children 6-18) |
| Other NYF Family Therapy and/or Preventive Services (BSFT, FFT, FFT-TCM, FFT-Behavioral Health, MST-PRV,  MST-EA, Safe Care, Mobility Mentoring) *Please Name Requested Program:* | | |
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| **PLEASE ATTACH ANY ADDITIONAL INFORMATION PERTINANT TO THE REFERRAL. THESE ITEMS INCLUDE BUT ARE NOT LIMITED TO:**   * Safety Assessment (safety strengths & barriers, safety checklist, safety plan) **please attach all active safety plans.** * Intake paperwork (Including any Psychiatric Measures completed) * Past psychiatric records (e.g., discharge summaries, medication and lab info, etc.) * Past medical records (e.g., hospital discharge summaries, medication, labs) * Past educational records including IEP, psychosocial, relevant report cards | | |

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| **PRESENTING INFORMATION** | | |
| **Reason for Referral/Presenting Symptoms:**  *(Describe specific behavioral, emotional, and/or relational problems. Please include relevant academic functioning and family conflict)* | | |
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| **Significant Events:**  *(Describe any significant events that may have affected the client’s current functioning, including relevant family information, medical history, and trauma history)* | | |
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| **For TF-CBT & CPT Referrals:**  *(Please check off any known trauma history)* | | |
| **Domestic Violence**  **Physical Abuse/Assault**  **Sexual Abuse/Assault** | **Sudden or Violent Death of Loved One**  **Natural Disaster, fire, or explosion**  **Serious accident** | **Life threatening injury or illness**  **Combat or exposure to war-zone**  **Community Violence** |
| **Other (*please list)*:** | | |

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| **Risk Assessment** | | | | |
|  | Current | Past | None | If yes, please explain |
| Suicidal Ideation/Behavior |  |  |  |  |
| Self-Injurious Behavior |  |  |  |  |
| Homicidal Ideation |  |  |  |  |
| Hallucinations/ Delusions |  |  |  |  |
| Substance/Alcohol Use |  |  |  |  |

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| **Psychiatric History** |
| Previous Mental Health Treatment History **Yes No**  If Yes, Please Explain *(include Treatment Type, Dates, Reason, Results):* |
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| Diagnosis Given *(if known)*: |
| History of *Psychiatric* Hospitalization?  **Yes  No** |
| If Yes, Please Explain *(include Name of Hospital, Date, Length of Stay, and Reason):* |
|  |
| History of Psychiatric Medication?  **Yes No** |
| If Yes, Please Explain *(include Medication, Dosage, Dates, Reason, Results):* |
|  |

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*Clinic Telephone: 917-485-7280; Fax number: 718-772-0289*