I&A

Home of Integrated Behavioral Health Referral Form

**Please send completed form to:** **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*