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

Date of Referral:		
CLIENT INFO		
Client Legal Name (*First & Last*):		
Client Chosen Name (*if different than legal*):		
Client Phone Number & Email:		
Address:		
Insurance Carrier:		
Insurance CIN Number:		
Please include photo of insurance card if possible		
Demographics		
D.O.B.:	Sex Assigned at Birth:	Pronouns:
School/Grade:	Ethnicity/Race:	Primary Language:
GUARDIAN INFO (18 & under)		
Legal Guardian Name:		
Relation to Client:		
Guardian Phone & Email:		
Primary Language:		
Is guardian aware of client's identity? ☐ Yes ☐ No		
If no, please explain:		
Does Client Reside with Legal Guardian? ☐ Yes ☐ No		
If no, please explain:		
Is Client Currently in Foster Care? ☐ Yes ☐ No		
If yes, Foster Parent Name & Contact:		
Is ACS currently involved? ☐ Yes ☐ No		
If yes, Case Worker Name & Contact:		
REFERRAL SOURCE INFORMATION		
Referral Source Name:		
Referral Source Phone & Email:		
Referral Source Agency (*If NYF, answer below):*		
Program:	Primary IP:	Start Date: Anticipated End Date:

SERVICES REQUESTED: Please only check *ONE* box
☐ **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** A joint child-and-parent therapeutic approach for children and adolescents experiencing significant emotional and behavioral difficulties related to traumatic life events. TFCBT occurs once weekly with a youth and their caregiver for approximately 16-25 weeks. ***Ages 5-21***
☐ **Cognitive Processing Therapy:** An evidence-based individual therapy that provides tools for older adolescents and adults to overcome traumatic experiences. CPT occurs once weekly with a therapist for 12 weeks. This is an intensive trauma-focused modality that requires the completion of practice assignments outside of session. ***Youth Ages 16-21 and/or Caregivers of Youth enrolled in a Clinic program***
☐ **MAP-CBT:** An approach to individual therapy that offers an array of evidence-based interventions for youth experiencing anxiety, depression, trauma, and behavioral issues. MAP can be a combination of individual and youth/caregiver treatment. Meetings occur weekly for 16-25 weeks. ***Ages 5-21***
☐ **Identity & Acceptance:** An array of clinical services for LGBTQIA+ youth and their families, including individual, group, and family therapy. ***Ages 0-21***
☐ **Circle of Security Parenting Group:** An 8-week group to support and strengthen secure caregiver/child relationships. ***Parents of children 0-8 (note, Youth to be listed as Client on this Form)***

PRESENTING INFORMATION

Reason for Referral/Presenting Symptoms:
(Describe specific behavioral, emotional, and/or relational problems. Please include relevant academic functioning and family conflict)

Significant Events:
(Describe any significant events that may have affected the client's current functioning, including relevant family information, medical history, and trauma history)

Trauma History: *(Please check off any known trauma history)*

☐ **Domestic Violence**	☐ **Sudden or Violent Death of Loved One**	☐ **Life threatening injury or illness**
☐ **Physical Abuse/Assault**	☐ **Natural Disaster, fire, or explosion**	☐ **Combat or exposure to war-zone**
☐ **Sexual Abuse/Assault**	☐ **Serious accident**	☐ **Community Violence**
☐ **Other (*please list)*:**		

Risk Assessment

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

Psychiatric History

Previous Mental Health Treatment History ☐ **Yes** ☐**No**
If Yes, Please Explain *(include Treatment Type, Dates, Reason, Results):*

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):*

Please send completed form to: MHCappointments@NYFoundling.org
Clinic Telephone: 917-485-7280; Fax number: 718-772-0289