**REFERRAL TO BEHAVIORAL HEALTH SERVICES**

**TO: Behavioral Health Provider**: Address:

Phone: *Office:* *Cell:*

Email: Fax:

**FROM: Primary Care Provider (PCP):** Address:

Phone: *Office:* *Cell:*

Email: Fax:

**RE:** **Patient Name**: Date of Birth:

Parent/Legal Guardian Name(s): \_\_

Address: \_\_

Home Phone: Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A release of information for this patient:** ☐ **is** **attached** ☐ **has already been sent**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Symptoms and Related Problems:**  **(check all that apply)** | **Mild** | **Moderate** | **Severe** |
| Aggressive Behavior |  |  |  |
| Alcohol or Substance Use |  |  |  |
| Anxiety |  |  |  |
| Autism Spectrum Concerns |  |  |  |
| Depression |  |  |  |
| Divorce or other Family Relational Concerns  *Specify*: |  |  |  |
| Eating-Related Concerns |  |  |  |
| Hyperactivity |  |  |  |
| Impulsive Behavior |  |  |  |
| Inattention/Concentration Difficulties |  |  |  |
| Mood Fluctuations |  |  |  |
| Oppositional Behavior |  |  |  |
| Psychosis |  |  |  |
| Self-Injurious Behavior |  |  |  |
| Suicidal Ideation (current) or History of Suicide Attempts |  |  |  |
| Trauma Exposure and/or Traumatic Stress Symptoms |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Specific referral questions/requests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient is having difficulty with:**

☐Family ☐School/Childcare ☐Peers ☐Alcohol/Drugs ☐Legal/Juvenile Justice

☐Other settings or stressors:

**Current medical diagnoses or conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Other concerns:**

☐ Significant Weight Changes: ☐ *gain* ☐ *loss*

☐ Frequent Nausea or Stomachaches

☐ Sleep Disturbances: ☐ *difficulty falling asleep* ☐ *mid-sleep awakening* ☐ *early a.m. awakening*

☐ Frequent Headaches

☐ Fatigue or Lack of Energy

**Current medication(s):**

*Medication: Dose: To treat:*

**Relevant child and family history:**

*Household type:*

☐Two parents ☐Single parent ☐Blended family ☐Relatives ☐Other:

*Developmental History:*

☐No concerns ☐Dev. delays ☐Birth trauma ☐Prenatal substance exposure ☐Other:

*School History:*

☐No concerns ☐Special education ☐Learning disabilities ☐School refusal/truancy

☐Suspensions/expulsions ☐Other:

*Systems involvement:*

☐None ☐In-home services ☐Outpatient mental health ☐School-based counseling ☐PT/OT

☐DCF ☐Juvenile Justice involvement ☐Other:

*Trauma history:*

☐ None ☐Physical abuse ☐Sexual abuse ☐Domestic violence ☐Bullying ☐Emotional abuse

☐ Neglect ☐Substance use by guardians (confirmed or suspected) ☐Other:

**Additional child or family information that might be of use in our work with this family:**

**Please contact me with any questions or concerns at the following:**

☐Office Phone ☐Cell Phone ☐Email ☐Fax

*(Add contact info here if different from above)*

Best times to reach me:

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**Primary Care Provider Signature** **Date**