



Client/Patient Demographics	
Referral Date:	Client/Patient Name:
Gender:	Date of Birth:
Race:	Full Address:
SSN#:	Zipcode:
Phone number:	School (if applicable):
Funding/Payment Source	
<input type="checkbox"/> Medicaid Provider:	Member ID#
<input type="checkbox"/> CSA/FAPT:	Notes:
<input type="checkbox"/> EBA/AMI:	Notes:
<input type="checkbox"/> Commercial Insurance:	Member ID#
Referral Source	
Name:	Agency (if applicable):
Phone:	Email:
Case Participants & Providers (Name, Phone, Email)	
Parent/Guardian/Caregiver:	
Other household member names:	
Other:	
Other:	
Other:	
Reasons for Service Request	
Behavioral Characteristics	School Characteristics (if applicable)
<input type="checkbox"/> Physical aggression	<input type="checkbox"/> Expelled or dropped out of formal education
<input type="checkbox"/> Verbal aggression	<input type="checkbox"/> Alternative school setting
<input type="checkbox"/> Theft	<input type="checkbox"/> Multiple suspensions for problem behavior
<input type="checkbox"/> Property destruction/Vandalism	<input type="checkbox"/> High association with antisocial school peers
<input type="checkbox"/> Substance Use	<input type="checkbox"/> Poor relationships with school staff
<input type="checkbox"/> Runaway	<input type="checkbox"/> Truancy
<input type="checkbox"/> Non-compliance with probation or court order	<input type="checkbox"/> Academic problems
<input type="checkbox"/> Non-compliance with family rules & expectations	
<input type="checkbox"/> History of inappropriate sexual behavior:	Peer Group Characteristics
<input type="checkbox"/> Parent-Child Conflict	<input type="checkbox"/> Gang membership or strong affiliation
<input type="checkbox"/> Sadness/Depression	<input type="checkbox"/> High affiliation with mostly antisocial peers
<input type="checkbox"/> Hospitalization History: #	<input type="checkbox"/> Mixed antisocial and prosocial peers
<input type="checkbox"/> Suicide Attempts: #	<input type="checkbox"/> Low affiliation with prosocial peers
<input type="checkbox"/> Other:	<input type="checkbox"/> Peer Relationship Problems
Brief Narrative Summary of Presenting Problem(s)	
PLEASE ATTACH ANY SUPPORTING DOCUMENTATION WITH THIS REFERRAL FORM	
<input type="checkbox"/> Social History	<input type="checkbox"/> Release of Information
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> CHINS approval/Court Order
<input type="checkbox"/> CANS (Most recent)	<input type="checkbox"/> Face Sheet
<input type="checkbox"/> YASI	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Please complete Referral Form and send with any additional documentation to
referrals@fpscorp.com