SALINA WEST PRTF

REFERRAL FORM

Saint Francis Community Services®

Serving Children and Families Since 1945

Date of Referral: ____________

SFCS – Salina West (785) 825-0563 or toll free (800) 435-1045 ***(5097 W. Cloud, Salina, KS 67401)***
Fax completed forms to (785) 825-0623

YOUTH:

Name ____________ **DOB** ____________ **Place of Birth** ____________

Home Address (*Incl city, state, zip*) ____________

Church Preference ____________ **Last school attended** ____________ **Current Grade** ____________

Ethnic Origin ____________ **Gender:** ____________ **Height** ____________ **Weight** ____________

Primary Language ____________ **Social Security #** ____________

United States Citizen ☐ **If No, where do you have citizenship?** ____________

PARENT 1

Name ____________ **DOB** ____________ **Gender:** ____________

Address ____________ **Social Security Number** ____________

Employer ____________ **Primary Language** ____________ **Work Phone** ____________

Home Phone Number ____________ **Cell Phone Number** ____________ **Occupation** ____________

United States Citizen ☐ **If No, where does this person have citizenship?** ____________

Custodial Parent ☐ Yes ☐ No

PARENT 2

Name ____________ **DOB** ____________ **Gender:** ____________

Address ____________ **Social Security Number** ____________

Employer ____________ **Primary Language** ____________ **Work Phone** ____________

Home Phone Number ____________ **Cell Phone Number** ____________ **Occupation** ____________

United States Citizen ☐ **If No, where does this person have citizenship?** ____________

Custodial Parent ☐ Yes ☐ No

OTHER GUARDIAN

Name ____________ **DOB** ____________ **Gender:** ____________

Address ____________ **Social Security Number** ____________

Employer ____________ **Primary Language** ____________ **Work Phone** ____________

Home Phone Number ____________ **Cell Phone Number** ____________ **Occupation** ____________

United States Citizen☐ **If No, where does this person have citizenship?** ____________

Custodial Parent ☐ Yes ☐ No

Person(s) to be contacted with questions and treatment decisions: ☐ Parent 1 ☐ Parent 2 ☐ Other Guardian

INSURANCE INFORMATION

Medicaid ☐Yes ☐No **MCO :** ____________ **Medicaid #:** ____________

Insurance ☐Yes ☐No **Name:** ____________ **Member #:** ____________ **Group#:** ____________

Insurance ☐Yes ☐No **Name:** ____________ **Member #:** ____________ **Group#:** ____________

*****Attach a picture of the front and back of the insurance card*****

Reason for Referral: ***(specific to harm to self or others)***

Client Behaviors:	**Date:**	**Description:**		
☐ **Aggression** ***(verbal, physical, etc.)***				
In Home:				
Out of Home:				
☐ **Use of Weapons:**				
☐ **Cruelty to Animals:**				
☐ **Sexual Behaviors:**				
☐ **Sexual Behavior To Others:**				
☐ **Promiscuity:**				
☐ **Fire Setting:**				
☐ **Stealing:**				
☐ **Breaking and Entering:**				
☐ **Gang Involvement/ Affiliation**				
☐ **Suicidal Thoughts, Threats or Attempts:**				
☐ **Self-Mutilation:**				
☐ **Identifying Marks** ***(Tattoos, Branding, body piercing)*****:**				
☐ **Runaway:**				
☐ **Curfew Violations:**				
☐ **Lies:**				
☐ **Alcohol/ Drug Use:** ***(When checked refer to D/A Counselor for SBIRT services or full evaluation)***		**Substance Used**	**Date last used**	**Problems**
☐ **Impulsive Behavior Placing Client at Risk:**				
☐ **Hyperactivity/ Attention Difficulty:**				
☐ **Eating Disorder** ***(beliefs, perceptions, attitudes and behavior regarding food)*****:**				
☐ **Other:**				

Placement History ***(If there is no information, obtain consent for information)*** **Most recent on top.**

Dates	**Name and Type of Placement**	**Reason**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

History of Mental Health Needs: ______________________

Has client recently seen a counselor/therapist? ☐Yes ☐No

If yes, identify who and why? ______________________

Has client had a psychological? ☐Yes ☐ No

If yes, date: ______________________ **Where:** ______________________

IQ scores ***(if available):*** ______________________ **Person administering test(s):** ______________________

Achievement Scores (if applicable):

Any Family History of Mental Health/Substance Use/Sexual Abuse/Physical Abuse/Domestic Violence/Legal Charges/ Other Trauma? ☐Yes ☐No

If yes, describe

History of DSM Diagnosis:

PAST MEDICATION	REASON

CURRENT MEDICATION/DOSAGE	REASON

LIST ANY ALLERGIES/MEDICAL CONDITIONS:

Information Provided By: ____________________

Relationship to Client: ____________________