REFERRAL - CLINICAL INFORMATION

Complete to the best of your knowledge
Submit Online or Fax Direct to Admissions: 918-497-4952
Call 800-821-6993 or 918-492-8200

PATIENT INFORMATION - REQUIRED

PATIENT NAME:		DATE:	
CUSTODY OF:		CUSTODIAN PHONE NUMBER:	
HOME ADDRESS:		GENDER: MALE FEMALE	AGE:
PHONE NUMBER:	ALTERNATIVE PHONE NUMBER (if available)		
PAYER:			
SECONDARY PAYER:			

REFERRAL SOURCE INFORMATION - REQUIRED

NAME:	AGENCY/ CLINIC/ SCHOOL:	RELATION TO CHILD:
PHONE:	ADDRESS:	
FAX:	EMAIL:	
TELEASSESSMENT PREFERRED?: YES NO	MOST CONVENIENT SITE?	

IMMEDIATE CLINICAL CONCERNS: PLEASE CIRCLE ALL THAT APPLY - REQUIRED

SUICIDAL/ SELF HARM	SUBSTANCE USE/ ABUSE	PSYCHOSIS	SEXUAL ACTING OUT	VIOLENT OR AGGRESSIVE	IMPULSIVE/ UNSAFE/ RUNAWAY RISK	UNSTABLE MEDICAL CONDITION	MEDICATION CONCERNS/ CHANGES	FALL RISK	OTHER:

CLINICAL INFORMATION - REQUIRED

MOST RECENT CLINICAL INFORMATION INCLUDING SPECIFICS ABOUT LAST 24-48 HOURS. USE ADDITIONAL SHEETS AS NECESSARY:

MEDICATION - REQUIRED

CURRENT MEDICATIONS:	RECENT CHANGES?:
IS THE CHILD COMPLIANT WITH MEDICATION? YES NO	IS THE FAMILY COMPLIANT WITH MEDICATION? YES NO
PREVIOUS MEDICATIONS AND OUTCOMES:	

PATIENT INFORMATION - OPTIONAL

PROBATION/ JUVENILE JUSTICE WORKER	YES NO	NAME & NUMBER:
DHS WORKER	YES NO	NAME & NUMBER:

CLINICAL HISTORY - OPTIONAL

DOES THIS PATIENT HAVE A HISTORY OF RISK BEHAVIORS? YES NO	HISTORY OF RISK BEHAVIORS AND IDEATION: (SELF HARM/ HARM TO OTHERS) DATE:________INCIDENCE:________________________________ DATE:________INCIDENCE:________________________________ DATE:________INCIDENCE:________________________________ DATE:________INCIDENCE:________________________________ USE ADDITIONAL SHEETS AS NECESSARY
HISTORY OF TRAUMA, ABUSE, OR NEGLECT? YES NO	BRIEF DESCRIPTION WITH ESTIMATED AGE AT TIME OF TRAUMA
PREVIOUS DIAGNOSES:	

FAMILY INFORMATION- OPTIONAL

WITH WHOM DOES CHILD CURRENTLY LIVE? TO YOUR KNOWLEDGE CAN THE CHILD RETURN TO THIS HOME? YES NO	NAME WHO LIVES IN THE CHILD'S CURRENT HOME:
PERTINENT FAMILY DYNAMICS:	
HAS THE CHILD CHANGED RESIDENCES? IF SO, WHAT WERE THE OUTCOMES:	

CONTINUUM OF CARE INFORMATION- OPTIONAL

CURRENT PRIMARY DIAGNOSIS: (IF AVAILABLE)
CURRENT OUTPATIENT COUNSELING PROVIDER & NUMBER:
CURRENT PSYCHIATRIST & NUMBER:
CURRENT PCP & NUMBER:
CURRENT COMPLIANCE WITH TREATMENT:

FOR OFFICE USE ONLY

DATE	ACTION