

**Day Treatment  
Referral to Integrated Family Services, PLLC**

Referral Date: \_\_\_\_\_ Name of Referral Source/Contact Information: \_\_\_\_\_

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Sex (circle) M F Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_ Town/City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ Town/City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Race (please circle) Black White American Indian Alaskan Native Asian/Pacific Islander Biracial

Ethnicity (please circle) Not Hispanic Origin Hispanic, Mexican American Hispanic, Cuban

Hispanic, Puerto Rican Hispanic, Other

Do You Speak English? Y N Do You Understand English? Y N

Current Medications Prescribed: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Guardian if Not Parent: \_\_\_\_\_ (relationship) \_\_\_\_\_

Does Guardian have legal custody? Y N

Emergency Contact: \_\_\_\_\_

**EDUCATION**

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

If not enrolled in school, what is the highest grade completed? \_\_\_\_\_

**INSURANCE**

Type of Insurance: Medicaid Y N Co-Pay: \_\_\_\_\_ Copy of Card Attached: Y N

Private Y N Co-Pay: \_\_\_\_\_ Copy of Card Attached: Y N

Name of Insurance Provider: \_\_\_\_\_

No Insurance: Y N

**REASON FOR REFERRAL** Use space on back for additional information

Referring behaviors that make client a candidate for Day Treatment Services: (Please include previous mental/behavioral services attempted.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Involvement:

\_\_\_\_\_

Current Living Situation: (Home, Group Home, Therapeutic Foster Care, etc)

\_\_\_\_\_

Transportation Needed: \_\_\_ Yes \_\_\_ No

Screened By: \_\_\_\_\_

Assessment scheduled for Date/time: \_\_\_\_\_ Therapist: \_\_\_\_\_