NFusion Metro

769-233-7429

REFERRAL FORM

DATE: ______________________________

Child's Name:______________________________ Age:____ Gender:___ Grade:________

Parent/Guardian Name:___________________________ Phone Number:______________

Referred by: ____

School : ________________ Teacher: __________________ Counselor: _______________

Current Medications:____

____

How long has this problem existed: _____ less than a month _____ 1-6 months _____ 6 months-1 year _____ over 1 year

Prior mental health services: YES NO If yes, where? ____

Check all that apply:

___Social Problem:

( )Bullies others ( )Scared to be alone ( )Deliberately annoys others ( )Deliberately avoids others [shy]

___Anger Problems:

( )Frequent fights ( )Argues often ( )Loses temper easily ( )Defiles rules

( )Aggressive ( )Disrespectful ( )Often angry

__Attention Problem:

( )Fails to finish ( )Talks excessively ( )Gets out of seat often ( )Forgetful

( )Daydreams ( )Can't sit still ( )Difficulty focusing ( )Impulsive

___Mood Problem:

( )Appetite change ( )Harms self ( )Lack of intrest in activities ( )Cries often

( )Low self-esteem ( )Thoughts of death ( )Severe mood swings ( )Worries often

___Other Problem:

( )Drug/alcohol use ( )Destruction of property ( )Legal Issues ( )Bedwetting

( )Grief issues ( )Sees things that aren't there ( )Hears things that aren't there

( )Truancy ( )Poor grades ( )School suspensions ( )Lies often

( )Plays with fire/matches ( )Cruel to animals ( )Sleep problems

( )Stealing ( )Sexual acting out ( )Runs away ( )Abuse or neglect suspected*

(If you suspect this child is being abused or neglected, it is YOUR responsibility to report it to the Department of Human Services.)

Comments:

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Date Referral From Received: ____________ Referral appropriate ? YES NO (If No, refer to appropriate agency.)

Notified Referral Source? Yes _______ No _________ if No, why? ____________________________________

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Action taken:

( ) Intake scheduled: YES NO If Yes, Date/Time ____

( )Observation scheduled : Date/Time ____

( ) Referred case to: ____

Date referral made________________________________

Comments:

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