Beech Brook

Outpatient Program Referral

Date: _____

Child Name:	
Current School:	Grade:
Home Address:	Zip Code:
Phone Number:	
Parent/Guardian Name: Was Parent/Guardian notified of referral? ☐ Yes ☐ No	
Insurance Type: ☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Unknown	

Name & Title of Person Initiating Referral:	
Phone:	Email:

Check all the concerns you have about your child:

☐ **Aggression** (arguing, forcing submission, bullying, fighting, stealing)

☐ **Disruptive Behavior** (defiance, noncompliance (teacher/school), not following rules, out of designated area)

☐ **Hyperactive Behavior** (tantrums, disturbing others, excess energy)

☐ **Withdrawn Behavior** (prefer being alone, non-participation, unresponsive to social initiations, not talking with others)

☐ **Depressed Mood** (overall sadness, low/restricted activity levels, crying, poor appetite)

☐ **Unassertiveness** (shy, being timid, not standing up for one's self)

☐ **Anxiety** (acting in a fearful manner, appears overly stressed, inability to cope with daily functioning)

☐ Other: _____

Please describe the reason for completing this referral:

Referral submitted by: _____