Beech Brook

Outpatient Program Referral

Date: _____

**Indicates a required field.*

***Child Name:**	***Date of Birth:**
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 ☐ None ☐ Unknown	***Insurance #:**

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☐ **Withdrawn Behavior** (prefer being alone, non-participation, unresponsive to social initiations, not talking with others)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

Forms should be emailed to Beech Brook's Intake Team at intake#032#team@beechbrook.org.

Referral submitted by: _____