

Outpatient Program Referral

**Date:**  Click or tap to enter a date.

|  |
| --- |
| **Child Name:** Click or tap here to enter text. |
| **Current School:** Click or tap here to enter text. | **Grade:** Choose an item. |
| **Home Address:** Click or tap here to enter text. | **Zip Code:** Click or tap here to enter text. |
| **Phone Number:** Click or tap here to enter text. |
| **Parent/Guardian Name:** Click or tap here to enter text.**Was Parent/Guardian notified of referral?** Choose an item. |
| **Insurance Type:** Choose an item. |

|  |
| --- |
| **Name & Title of Person Initiating Referral:** Click or tap here to enter text. |
| **Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text. |

**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[ ]  **Withdrawn Behavior** (prefer being alone, non-participation, unresponsive to social initiations, not talking with others)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**: Click or tap here to enter text.

|  |
| --- |
| **Please describe the reason for completing this referral:**Click or tap here to enter text. |

Referral submitted by: Click or tap here to enter text.