Referral Form for Methodist Residential Programs

Please complete form in FULL and fax back to (501) 421-6477

Client Name: _____ **Date Completed**: _____

SSN: _____ **DOB**: _____ **Age**: _____

Birth Gender: ☐ **Male** ☐ **Female** **Gender Identity (if applicable)**: ☐ **Male** ☐ **Female**

Medicaid	**Private Insurance**
PASSE Assignment:	**Insurance Carrier:**
PASSE ID #:	**Policy #/Group #:**

Provider Name: _____ **Therapist Name**: _____

Therapist Phone Number: _____ **Therapist email**: _____

Family/Guardian Contact Information:

Name/Relation: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Psychiatric Diagnosis ICD-10 Code (F Code): _____

IQ/Functioning Level: _____

What psychiatric symptoms present that cannot be maintained at a lower level of care? Please be detailed & specific:

Other issues/behaviors impeding successful OP services and other social environmental success:

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How is this reflective of mental illness versus conduct related behavior?

Clients Current Location: ☒ Home ☐ QRTP/Foster Home ☐ Detention ☐ Hospital ☐ Other_____

Current members of household, age, and relationship to client:

Member of Household	Age	Relationship to Client

Education:

School: _____ Grade: _____

If not currently attending school, please explain: _____

_____

Psychosocial Stressors:

☐ Birth	☐ Financial Difficulties in Family	☐ Parent Instability
☐ Custody Issues	☐ Health Issues in Family	☐ Peer Conflict
☐ Divorce/Separation	☐ Marriage	☐ Relocation
☐ Family Conflict	☐ Witnessed Violence	☐ Other

Legal Involvement: ☐ Yes ☐ No

Name & Number of Probation Officer:_____ County: _____

Reason for Legal Involvement:_____

_____

Primary Care Physician Name/Clinic and Contact Number: _____

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Current Risk Factors of Suicide:

☐ Child/Parent Conflict	☐ Isolation/Withdrawn	☐ Poor Impulse Control
☐ Crying Spells	☐ Lack of Appetite	☐ Restless
☐ Excessive Worry	☐ Mood Swings	☐ Sad/Depressed
☐ Fatigue	☐ Sleep Disturbance	☐ Hopeless
☐ Panic Attacks	☐ Feeling of Worthlessness	☐ Irritable/Agitation
☐ Peer Conflict	☐ Recent Loss	☐ Other

Current or History of Suicidal Ideations? _____

History of Suicide Attempts:

Date	Method of Attempt

Self-Injurious Behaviors:

☐ None	☐ Bangs Head	☐ Punches Walls
☐ Bites Self	☐ Picks Sores	☐ Punches/Slaps Self
☐ Burns Self	☐ Pulls Hair	☐ Scratches Self
☐ Cuts Self	☐ Other	

Please explain the last occurrence of Self-Injurious behavior: _____

Risk Factors of Violence/Homicide:

☐ Blames Others	☐ Easily Annoyed/Annoys Others	☐ Oppositional
☐ Cruelty to Animals	☐ Gang-Related Activity	☐ Difficulty with Authority
☐ Lack of Remorse	☐ Serious Violations of Rules	☐ Other
☐ Use of weapons	☐ Violence towards others	☐ Destruction of Property
☐ Fire setting		

Current or History of Homicidal Ideations: _____

Provide details of risk factors of violence/homicide endorsed above:

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Psychosis/Functioning Factors
History of Psychosis:

Family History of Mental Illness, Medical Illness, or Substance Abuse:
Outpatient Treatment History:

Total # of Individual Sessions by LHMP within the last 90 days: _____
Have Individual Sessions been increased to address current issues? ☐ Yes ☐ No
Total # of Family Sessions by LHMP within the last 90 days: _____
Total # of Crisis Interventions within the last 90 days: _____
Date of most recent family/individual session attended: _____

Inpatient Treatment History:

Date	Location	Reason for Admission

Current Medications:

Medication Name	Dosage	Frequency Taken

Does the client take medications as prescribed: ☐ Yes ☐ No

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Medical History **Height: _____ Weight: _____**

Current/prior medical diagnoses (i.e., diabetes, congestive heart disease, surgeries, etc.): _____

_____

_____

Does the patient require any assistive devices/services: ☐ Yes ☐ No

Allergies: ☐None ☐Drug ☐Seasonal ☐Other (If yes to any, please list all known allergies):_____

_____

_____

Substance Abuse History: ☐ Yes ☐ No

If yes, provide details to include frequency: _____

_____

Is substance abuse a primary contributing factor to this referral? ☐ Yes ☐ No

_____

Has patient completed or is patient attending drug treatment/groups? ☐ Yes ☐ No

If yes, provide details: _____

_____

_____

Trauma, Abuse, Neglect and/or Exploitation History (if yes, please note date, specifics of incident & those involved):

Sexual Abuse: ☐Yes ☐No _____

_____

Physical Abuse: ☐Yes ☐No _____

_____

Neglect: ☐Yes ☐No _____

_____

Exploitation: ☐Yes ☐No _____

_____

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Risk of Sexually Acting Out:

☐ None Reported	☐ Exposing Self to Others	☐ Multiple Partners within the Last Year
☐ Inappropriate Touching	☐ Sexually Active	☐ History of in Hospital SAO
☐ History of overly solicitous sexual behavior	☐ Allegations of Sexual Perpetration on others	☐ Excessive/Public Masturbation
☐Pending investigation/hx of founded SAC (P)	☐ Hx of making unfounded sexual allegations on others	☐ Other:

Same-Sex Attraction: ☐ Yes ☐ No

Symptoms of potential abuse (victim or perpetrator):

☐ None Reported	☐ Exposing Self to Others	☐ Multiple Partners within the Last Year
☐ Encopresis	☐ Enuresis	☐ History of in Hospital SAO
☐ Inappropriate Touching	☐ Allegations of Sexual Perpetration	☐ Excessive/Public Masturbation
☐ Low Functioning/Low Impulse Control due to ID/Neuro	☐ Sexually Active	☐ Encopresis
☐ Enuresis		☐ Other:

Therapist Signature **Date**

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