



# Norris Academy

## REFERRAL APPLICATION

Date of Referral:

Referral Contact:

Child's Name:

Date of Birth:

Social Security #:

Parent/Guardian Name:

Relationship to Child:

Address:

Phone Number:

Primary Insurance:  
Insurance ID #:

Secondary Insurance (If Applicable)  
Insurance ID#:

Reason for Referral:

Primary Diagnoses:

Diagnosing Clinician:

Date Diagnosis was given:

**History of Psychiatric and Mental Health Services** (please include current and past providers, acute hospitalizations and residential treatment, including dates of service):

**Medical History** (please list allergies, past or current medical conditions, and critical medical needs):

Current PCP:

Phone Number:

Date of Last Visit:

Neurologist:

Phone Number:

Date of Last Visit:

Endocrinologist:

Phone Number:

Date of Last Visit:

**Height:**

**Weight:**

**Current Involvement of Department of Children's Services:**

Is youth in DCS Custody:

Name of Current DCS case manager:

Contact Number:

County:

Utilization Review Person:



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**Current medications:**

Name and dosage:	Frequency of Use:	Administration:

**If necessary to maintain safety, is there any reason child could not be physically restrained:**

**Any hospitals that would refuse/have refused to admit child for psychiatric care:**

**IQ (specify testing tool utilized):**

**Suicidal Ideation/Homicidal Ideation: (if so, when)**

**Self-harmful behaviors: (if so, when)**

**Psychosis: (hallucinations, delusions)**

**Alcohol and Drug usage (past and present):**

**Family history of Alcohol & Drug use:**

**Family history of mental health:**

**History of Abuse (physical, sexual, victim, perpetrator; past and present):**

**Aggression (be very descriptive, how often, what type of aggression):**

- *Property Destruction-*
- *Fire Setting-*
- *Cruelty to Animals-*



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**Other behaviors** (including depression, anxiety, impulsiveness, hyperactivity):

- *Mood-*
  
- *ADLs(can patient complete hygiene/dressing self independently, and if not what level of assistance does patient require?)-*
  
- *Academic-*
  
- *Legal-*
  
- *Expressive communication-*
  
- *Behaviors-*
  
- *Any sexual acting out behaviors: (victimization/perpetration)*

**Current Living Situation** (include persons living in home, relationships and ages):

**If adopted/foster child:** (when did they come to live with current family and for what reason)

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Signature

Date