101 First Quality Drive
Andersonville, TN 37705
(Direct) 865-494-5554
(Fax) 865-205-7287

REFERRAL APPLICATION

Date of Referral:	**Completed By:**
Referral Source:	Child's Name:
Referral agency:	Date of Birth:
Best way to reach you? Email Phone	
Email address: Phone Number:	Social Security #:
Parent/Guardian Name:	Relationship to child:
Phone Number:	Address:
Email address (optional):	County:
Primary Insurance: Insurance ID #:	Secondary Insurance: Insurance ID #:
Primary Diagnoses:	Diagnosing Clinician:
Date Diagnosis was given:	

Describe in detail child's current condition, including mental status ad behavior symptoms, for which Residential Treatment might be needed. (Attach additional pages if needed).

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

Treatment/Mental Health Services	**Provider(s)**	**Start/End Dates**	**Comments**
Individual Therapy			
CCFT			
ABA			
Medication Management			
Psychiatric Hospitalization(s)			

Current Involvement of Department of Children's Services	
Is youth in DCS Custody: No Yes	Date entered:
Has the child been Adjudicated Delinquent or Dependent/Neglect by the court? No Yes (if yes, documentation is required)	
Name of Current DCS case manager:	Contact Number:
Any Legal Involvement (please describe):	

Medical History	
Allergies:	**Reactions:**
Height:	**Weight:**
Current PCP: Date of Last Visit:	Phone Number:
Neurologist: Date of Last Visit:	Phone Number:
Endocrinologist: Date of Last Visit:	Phone Number:
Specialist: Date of Last Visit:	Phone Number:
Specialist: Date of Last Visit:	Phone Number:
If necessary to maintain safety, I there any reason child could not be physically restrained: No Yes	
Any Hospitals that would refuse/have refused to admit child for psychiatric care: No Yes	
Alcohol and drug usage (past and present): No Yes	
History of abuse (physical, sexual, neglect, victim, perpetrator; past and present)	
Family history of alcohol and drug use:	
Family history of mental health:	

Current/Past Psychiatric Medications:

Medications	Dose/Frequency	Start/End Dates	Comments

Current living situation (include persons living in the home, relationships, and ages):

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

Mental Health Status and Behavior Symptoms

Behaviors of concern (be very descriptive, how often, what type of aggression):

Destruction of property-

Fire setting-

Cruelty to Animals-

Self-injurious behavior-

Physical aggression-

Problem sexual behaviors (victimization/perpetration)

ADLs (can child complete hygiene/dressing self independently, and if not what level of assistance does the child require?-

Mood (including depression, anxiety, impulsiveness, hyperactivity)-

Suicidal Ideation/Homicidal Ideations (if so, when): No Yes

Self-harmful behaviors (if so, when): No Yes

Psychosis (hallucinations, delusions): No Yes

Education

Academics-

Expressive communication-

Does the youth currently have an IEP: No Yes

Does the youth have a formal educational Autism diagnosis: No Yes

IQ (specify testing tool utilized):