101 First Quality Drive
Andersonville, TN 37705

Office: 865-494-5554
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REFERRAL APPLICATION

Date of Referral:	**Completed By:**
Child's Name:	Date of Birth:
Gender:	Social Security #:
Referral Source:	Referral agency:
Email:	Phone:
Guardian(s) Name(s):	Relationship to child:
Phone Number(s):	Address:
Email address:	
Primary Insurance:	Secondary Insurance:
Insurance ID #:	Insurance ID #:
Primary Diagnoses:	Diagnosing Clinician(s):
Approximate dates diagnoses given:	

Describe in detail the child's current condition, including mental status and behavior symptoms, for which Residential Treatment might be needed. (Attach additional pages if needed). <u>History of Psychiatric and Mental</u>

<u>Health Services</u> (please include current and past providers, acute hospitalizations and residential treatments):

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:
<u>If necessary to maintain safety, is there any reason child could not be physically restrained</u>: No Yes If yes, please explain:	
<u>Any Hospitals that would refuse/have refused to admit child for psychiatric care:</u> No Yes If yes, please explain:	
<u>Alcohol and drug usage (past and present):</u> No Yes If yes, please explain:	
<u>History of abuse (physical, sexual, neglect, victim, perpetrator; past and present):</u>	
<u>Family history of alcohol and drug use:</u>	
<u>Family history of mental health:</u>	
Education	
Current Grade:	
Level of expressive communication (verbal, non-verbal, limited verbal) -	
<u>Does the youth currently have an IEP:</u> No Yes	
<u>Does the youth have a formal educational Autism diagnosis:</u> No Yes	
<u>IQ (specify testing tool utilized):</u>	

Current/Past Psychiatric Medications:

Medications	Dose/Frequency	Start/End Dates	Comments

Mental Health Status and Behavior Symptoms
Behaviors of concern (**be very descriptive, include frequency, type, and severity**)
Destruction of Property –
Fire setting -
Cruelty to Animals -
Self-injurious behavior -
Physical aggression -
Elopement -
Problem sexual behaviors (victimization/perpetration) -
ADLs - Can the child complete hygiene/dressing self independently? If not, what level of assistance does the child require?
Mood (including depression, anxiety, impulsivity, hyperactivity, etc):
Suicidal Ideation/Homicidal Ideations: No Yes If yes, please explain:
Self-harm behaviors: No Yes If yes, please explain:
Psychosis (hallucinations/delusions): No Yes If yes, please explain:

Current living situation (include persons living in the home, relationships, and ages):
If adopted/foster child, when did the child come to live with the current family and for what reason: