Respite Referral Form

DATE referral received: _____

Primary language: ☐ English ☐ Other: _____
(Please specify language)

DEMOGRAPHIC INFORMATION

Client Name:_____ DOB: _____

SSN:_____ Sex: ☐ M ☐ F

Primary Contact:_____ Relationship to client:_____

Address: _____ Home #: _____

_____ Cell #: _____

Email: _____

Primary Insurance Type: ☐ UBH ☐ NHP ☐ Tufts ☐ Medicaid Other_____

Member ID:_____ Group ID _____

DIAGNOSTIC INFORMATION

Diagnosis (DSM V): _____

Diagnosed by: _____ Approximate Date: _____

PROVIDERS

Primary Care Physician: _____ Phone Number: _____

Relevant Medical information: _____

_____

School Name: _____ Grade: _____

IEP: ☐ Yes ☐ No Supports: ☐ Speech ☐ OT ☐ PT ☐ APE ☐ ESY ☐ Other Accommodations

Other Services child is receiving at this time: ☐ Yes ☐ No

_____

OTHER:

_____

_____

_____

_____

REFERRAL INFORMATION

Referral Name:_____ Phone:_____

Agency/Affiliation:_____

REFERRAL CHECKLIST

☐ Parent/guardian was informed they need to supply documentation from a medical professional confirming the child's diagnosis

☐ Parent/ guardian has agreed to complete an adaptive assessment and have the document ready and available at the intake appointment.

OFFICE USE ONLY: **Phone Log**

Date	Time	Outcome

Coordinator Assigned: _____

Intake to be completed on or before: _____ **OSB ID**: _____

Date of first contact with parent/ guardian: _____ **Date script received: _____**