

Olson Huff Center for Child Development
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Referral Intake Form

PLEASE COMPLETE AND FAX TO 213-1785

Referral does not guarantee appointment

Please allow 10 business days for appointments to be reviewed and scheduled

Health Care Provider making referral: _____

Telephone: _____ Fax: _____ Address: _____

Patient's Full Name: _____ Date of Birth: _____ Patient's Age: _____

Patient's Mailing Address Street: _____ Town: _____ Zip: _____

Parents Names: Mother: _____ Father: _____

Other relative or Guardian: _____

Patient Home Phone: _____ Work Phone: Mother _____ Father _____

Cell Phone: Mother _____ Father _____ Other contact: _____

Is an interpreter needed? **Yes** **No** Insurance Information: _____ ID# _____

TO BE COMPLETED BY THE REFERRING PROVIDER ONLY

Referring Concern _____

What other providers has this child seen for this concern or diagnosis?

Established or suspected diagnosis: _____

Previous Psychoactive Medications: _____

Current Medications _____

Previous Psychiatric Evaluation? **Yes** **No** Previous Psychiatric Hospitalizations? **Yes** **No**

History of Abuse? **Yes** **No** History of Suicide or Self Harm? **Yes** **No**

History of current or previous trouble with the law or substance abuse? **Yes** **No**

Expelled from school (not suspension)? **Yes** **No**

Please rate urgency of your referral (Circle one). **Routine** **Semi - Urgent** **Urgent** (and if so why?)

OFFICE USE ONLY

Disposition

Appointment date: _____ Referred to other agency: _____ Unable to reach patient: _____

COMMENTS: _____

Signature: _____

Date: _____