Western New York Children's Psychiatric Center
1010 East and West Road
West Seneca, New York 14224
Telephone: (716) 677-7000
Fax #: (716) 677-7076 OR 675-6455

INPATIENT REFERRAL

Referral Source:_____ **Date:** _____/_____/_____

Contact Person:_____ **Telephone #: ( )** _____

Child's Name: _____ **SEX: Male**_____ **Female** _____ **DOB:** _____/_____/_____

Child's Address: Street:_____ __ **City:**_____ **State:**_____ **Zip Code:**_____

PARENTAL CUSTODY: Y_____ **N**_____ **GUARDIANSHIP: Y**_____ **N**_____ **LANGUAGE SPOKEN BY CHILD:** _____
LANGUAGE SPOKEN BY FAMILY: _____

PARENT/GUARDIANSHIP/CUSTODIAN: _____
(Circle One)
ADDRESS: (If different from child)
Street:_____ **City:**_____ **State:**_____ **Zip Code:**_____ **County:**_____

TELEPHONE #'S: H ( ) _____ **W ( )** _____ **CELL #:** _____

DATE OF HOSPITAL/AGENCY ADMISSION: _____/_____/_____ **DATE OF REFERRAL:** _____/_____/_____

MENTAL HEALTH LEGAL STATUS (IE: 2PC, minor voluntary)_____

HISTORY OF ABUSE – SEXUAL: Y_____ **N** _____ **PHYSICAL: Y** _____ **N** _____

CPS INVOLVEMENT: Y_____ **N** _____ **CPS OPEN:** ____ **CLOSED:** _____ **CPS WORKER:**_____ **PHONE:**_____

REASON:_____

LEGAL INVOLVEMENT: Y_____ **N** _____ **CHARGES: Y**_____ **N**_____ **SPECIFY CHARGE:**_____
PINS: Y _____ **N** _ ____ **FAMILY COURT JUDGE:** _____ **PHONE:** _____

LAW GUARDIAN/PHONE #:_____ **PROBATION/PHONE:** _____

INS. CO. & #:_____ **MEDICAID #:**_____ **SOC. SECURITY #** _____ -_____ - _____

SCHOOL DISTRICT: _____ **SCHOOL:**_____ **GRADE:**_____

HEIGHT_____ **WEIGHT:**_____

REASON YOUTH NEEDS INTERMEDIATE HOSPITALIZATION:
_____
_____

SIGNIFICANT CONTACTS:
1) NAME _____ **PHONE:** _____ **AGENCY:** _____
2) NAME _____ **PHONE:** _____ **AGENCY:** _____
3) NAME _____ **PHONE:** _____ **AGENCY:** _____

MANDATORY ATTACHMENTS:

_____ Psychiatric Assessment (most recent) **_____ Social History** **_____ Consent for Referral**
_____ Medication Reconciliation **_____ Recent IQ Test** **_____ SPOA Application/Services**
_____ Medical History (include Med diagnosis/allergies) **_____ Immunization log and PPD**

TRIGGERS/INTERVENTIONS/SAFETY PLAN:_____
_____
_____

CURRENT BEHAVIORS: (sexualized, aggressive, suicidal)_____
_____
_____

ALERTS (IE: assault, 1:1, self harm, escape)_____
_____
_____

→ ALL MANDATORY INFORMATION MUST BE RECEIVED BEFORE REFERRAL WILL BE REVIEWED.
IF AVAILABLE: _____ Psychological Testing _____ IEP _____ Custody/Guardianship papers if other than with parents

COMPLETED BY: (print name) _____ **WORK TEL. #: ( )** _____
Signature: _____ **FAX #: ( )** _____ **(3/09)**