BEHAVIOR CARE SPECIALISTS, INC.
REFERRAL FORM

PATIENT INFORMATION

NAME _____ _____ _____
LAST FIRST MI

DATE OF BIRTH _____/_____/_____ GRADE _____ SEX ☐ MALE ☐ FEMALE

PARENTS/LEGAL GUARDIAN INFORMATION

MOTHER

NAME _____ _____
LAST FIRST

RELATIONSHIP TO PATIENT (IF NOT PARENT, PLEASE PROVIDE LEGAL DOCUMENTATION OF GUARDIANSHIP)

☐ PARENT ☐ GUARDIAN ☐ FOSTER PARENT ☐ OTHER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____ MAY WE CONTACT YOU AT THIS NUMBER ☐ YES ☐ NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL

FATHER

NAME _____ _____
LAST FIRST

RELATIONSHIP TO PATIENT (IF NOT PARENT, PLEASE PROVIDE LEGAL DOCUMENTATION OF GUARDIANSHIP)

☐ PARENT ☐ GUARDIAN ☐ FOSTER PARENT ☐ OTHER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____-_____ CELL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____ MAY WE CONTACT YOU AT THIS NUMBER ☐ YES ☐ NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL

SCHOOL/DISTRICT/AGENCY INFORMATION

TYPE OF ORGANIZATION ☐ SCHOOL ☐ SCHOOL DISTRICT ☐ AGENCY

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY CONTACT _____

PHONE (_____) _____-_____ FAX (_____) _____-_____

EMAIL ADDRESS _____

DATE BEGAN SERVICES _____/_____/_____

REFERRAL INFORMATION

INDIVIDUAL MAKING REFERRAL _____ _____
LAST FIRST

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY CONTACT _____

PHONE (_____) _____-_____ FAX (_____) _____-_____

EMAIL ADDRESS _____

DIAGNOSIS

PLEASE LIST ANY CURRENT/PREVIOUS DIAGNOSES MADE

_____

_____

_____

_____

_____

WHEN WERE THE CURRENT/PREVIOUS DIAGNOSES MADE _____/_____/_____

WHO MADE THE CURRENT/PREVIOUS DIAGNOSES

DOCTOR'S NAME _____

CLINIC NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICATIONS

LIST PRESCRIPTIONS, OVER THE COUNTER AND HERBAL SUPPLEMENTS PATIENT IS CURRENTLY TAKING

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

MEDICATION _____ DOSAGE _____ FREQUENCY _____

NOTE ANY ADDITIONAL MEDICATIONS OR SPECIAL INSTRUCTIONS BELOW_____

_____

_____

_____

_____

_____

DESCRIBE EDUCATION/VOCATIONAL PROGRAMMING CURRENTLY IN PLACE FOR THE PATIENT _____

_____

_____

_____

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_____

DESCRIBE THE STRATEGIES YOU HAVE FOUND TO BE HELPFUL WHEN WORKING WITH THIS PATIENT _____

_____

_____

_____

_____

_____

PRESENT CONCERNS

ACADEMIC/VOCATIONAL SKILLS

_____

_____

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BEHAVIORAL SKILLS

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COMMUNICATION/HEARING

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MEDICAL

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MOTOR (GROSS AND FINE)

OTHER

REASON FOR REFERRAL

LEVEL OF SERVICES REQUESTED (CHECK ALL THAT APPLY)

☐ CONSULTATION
Consultant provides on-site observation and recommendation to school, agency or family regarding client observations and conclusions.

☐ CLINICAL SERVICES MODEL
Behavior Care Specialists, Inc. therapists provide a minimum of 25-40 hours of direct therapy a week, in the home, school or community setting. Therapy is based on the principles of Applied Behavior Analysis.

☐ IN-SERVICE/TRAINING
Consultant provides on-site training and workshops for school or agency staff who will be providing continuous intervention services to their students or agency clients.

☐ FAMILY CONSULT MODEL
Consultant provides training and workshops to client's parents, care providers and other individuals who will assist in ongoing therapy.

☐ FUNCTIONAL ASSESSMENT
Consultant will observe and determine the function of the client's behavior based upon the information and data collected. Additionally, consultant will provide assistance in developing a Behavioral Intervention Plan.

☐ EVALUATIONS

☐ Cognative ☐ Educational ☐ Adaptive Behavior

☐ Autism Rating Scale ☐ Asperger Rating Scale

☐ OTHER

Specify _____

_____ _____/_____/_____

Printed name of Client or Parent/Legal Guardian Date

_____

Signature of Client or Parent/Legal Guardian

If the individual being referred is 18 years old or older, he/she must sign above unless guardianship has been established by a parent or another individual. If guardianship has been established, please include a copy of guardianship papers.