

Client Name:		Medical Record #	
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REFERRAL PROCESS:

1 – Complete Referral Application

2 – PPP Staff review application for program acceptance

3 – If approved, submit the following:

- Signed PCP, including interventions for day treatment
- Most recent Diagnostic or Clinical Assessment, including Axis I through Axis V

Nickname		DOB		Race		<input type="checkbox"/> M <input type="checkbox"/> F	SSN	
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CURRENT RESIDENCE

Birth Family Adoptive Family Level I Foster Care Level II Thera/F.Care Level III Group Home Other

Address _____

Please indicate with whom the child currently resides and their contact information:

NAME	RELATIONSHIP	PHONE NUMBERS

If the child does not live with birth family, is the birth family involved? Yes No *If yes, please specify below:*

NAME	RELATIONSHIP	PHONE NUMBERS

INSURANCE INFORMATION

Medicaid IPRS Health Choice Other **Policy #** _____

EDUCATIONAL INFORMATION

Grade: 5th 6th 7th 8th 9th 10th 11th 12th **Is client currently attending school?** Yes No

Current/Last School Attended _____ **Main Number** _____

Does this client currently have an IEP? Yes No **IEP Contact** _____

Is this client currently on a modified day home hospital long term suspended?

If yes to either, please describe the current situation/schedule _____

TREATMENT TEAM MEMBERS

NAME	TITLE	AGENCY	PHONE NUMBER(S)

MEDICATIONS

Medication	Dosage	Frequency	Prescribed By & Contact #	Compliance?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

