REFERRAL FORM

Patient Name:		Date of Referral:	

SSN:		Age:		DOB:		Sex:		Ethnicity:	

Guardian Name:		Relationship:	
Guardian Name:		Relationship:	

Address:		Hm Ph#		Wk Ph#		Cl Ph#	
City:		State:		Zip:		Email:	______

Referral Source Name:		Phone:	
Referral Source Agency Name:		Email:	

Last program attended at Bernalillo Academy		within 60 days	☐	more than 60 days	☐	N/A	☐

Service(s) being requested:		Discharge Status:	

Current Location of Child:	
Is the client a danger to himself or other?	☐ Yes ☐ No
If yes, was the referral source advised to obtain emergency services? ☐ Yes ☐ No	

Presenting Problems (briefly describe why seeking services, including diagnosis; medical issues; psychological status, cognitive functioning (FSIQ score if available); social environment status; family status, etc.)

Education (school, grade, special ed):	
Assessment time or clinical information to be forwarded:	
Prior Treatment:	
Response to Treatment:	

Medications:					
Primary Care Physician:					
Comments:		**Phone#**		**Fax#**	

Check those that have been requested at time of referral: ☐ **Birth Certificate** ☐ **Shot Record** ☐ **Social Security Card**
Have you applied for the Developmental Disabilities (DD) waiver? Yes or No or N/A
Primary Insurance Name:
Medicaid #
Policy #
Secondary Insurance Name:
Medicaid #
Policy #
Other Insurance: