Phone: (412)665-0600

Fax: (412)665-0755

Family Focused Solution Based Services
Child Referral Form

Referral Agency:	Contact:	Phone/E-mail:

Consumer Name (First, Last):
Address:
DOB:
SSN:
CCBHO/MA#:

Legal Guardian(s):	Address: (if different from Consumer)
Relationship to Consumer:	Phone number(s):
Biological Mother:	Address: (If different from above) Phone:
Biological Father:	Address: (If different from above) Phone:

LIST ALL OTHERS LIVING IN THE HOME

Name	Age	Relationship to Consumer

School/ District:
Grade:
Educational Placement (504,IEP):
Additional information:

Mental Health Diagnosis (suspected, current):
Physical Health Concerns:

PCP:	**Facility:**	**Contact number:**
Psychiatrist/Psychologist (if applicable):	**Facility:**	**Contact number:**

Risk of out of home placement? Y / N Explain:

Symptom Checklist:

◯ Sexually acting out	◯ Theft	◯ Truancy/ School Refusal
◯ Anxiety	◯ Criminal Mischief	◯ Property Destruction
◯ Depression	◯ Arson	◯ Use of Alcohol
◯ Hyperactivity/ Impulsivity	◯ Criminal Conspiracy	◯ Use of Drugs
◯ SI	◯ Vandalism	◯ Runaway
◯ HI	◯ Simple Assault	◯ Curfew Violations
◯ SIB	◯ Aggravated Assault	◯ Verbal Aggression
◯ Delinquent peer group	◯ Probation Violations	◯ Physical Aggression
◯ Cognitive/ Developmental	◯ Trauma	◯ Family Relational Issues

Referral Concerns: (Include symptoms, family/ community interactions, behavioral concerns, etc…)

Previous and Current Mental Health Treatment	Dates of Service	Facility/ Provider
◯ Outpatient		
◯ Partial		
◯ BHRSCA (wraparound)		
◯ Family-Based/ Focused		
◯ Psychiatric hospitalization		
◯ Residential Treatment Facility		
◯ CM/ SC		
◯ Other (specify)		

Current OCYF Involvement: Y / N	**Contact:** **Phone:**
Current JPO Involvement: Y / N	**Contact:** **Phone:**