LECOM HEALTH

PRTF REFERRAL FORM

		DATE SENT:
DEMOGRAPHIC INFORMATION		
NAME:	DOB:	SSN:
SEX ASSIGNED AT BIRTH:	GENDER ID:	
HOME ADDRESS:	CITY, STATE, COUNTY:	
REFERRAL SOURCE		
NAME:		AGENCY:
PHONE:		EMAIL:
CURRENT PLACEMENT		
CURRENT PLACEMENT:	ADDRESS:	DATE OF ADMISSION:
INSURANCE INFORMATION		
PRIMARY INS:	POLICY #	
SECONDARY INS:	POLICY #	
TERTIARY INS:	POLICY #	
ISPT		
Has an ISPT been held? If yes, include date. If no, please indicate if ISPT has been scheduled		
Interviews with the youth & family are a part of the referral review process. If you have scheduled, please list date and time. If this has not been scheduled, please reach out to the program supervisor (814) 868-8286 to schedule.		

PARENT/LEGAL GUARDIAN/FAMILY UNIT		
NAME:		RELATIONSHIP:
PHONE:		ADDRESS:
E-MAIL:		
NAME:		RELATIONSHIP:
PHONE:		ADDRESS:
E-MAIL:		

Is there a custody agreement in place?
Please provide custody timeline: (Please include approximate time frames and names of guardians)
Who is the discharge resource identified to participate in weekly therapy and welcome the child back into their home following 14-60 days of treatment?

OCY Involvement	
Current:	History:
If yes, to current, caseworker name, phone number and e-mail:	
If yes, to current or history, please provide details:	

JPO Involvement	
Current:	History:
If yes, to current, caseworker name, phone number and e-mail:	
Please list past or pending charges:	
If yes, to current or history, please provide details:	

EDUCATION INFORMATION	
School Name:	Address:
Grade:	IEP:
School Contact:	
School Contact Phone:	School Contact E-Mail:

MEDICAL INFORMATION			
PCP:	PCP PHONE:	Diabetic:	Height: Weight:
Non-Psychiatric Diagnoses:			
Dietary Restrictions:			
Special Needs:			
Allergies:			

CURRENT MEDICATION (INCLUDE ALL CURRENT PRESCRIBED MEDICATIONS, INCLUDING VITAMINS AND NON-PSYCHIATRIC MEDICATIONS)		
MEDICATION	DOSE	TIME

CURRENT SERVICES/PROVIDERS		
FBMH:		AGENCY:
CONTACT:	PHONE:	EMAIL:
SERVICE OPEN DATE (month/year):		
SERVICE TYPE:		AGENCY:
PHONE:		
SERVICE OPEN DATE (month/year):		
SERVICE TYPE:		AGENCY:
PHONE:		
SERVICE OPEN DATE (month/year):		
SERVICE TYPE:		AGENCY:
PHONE:		
SERVICE OPEN DATE (month/year):		

INVESTMENT IN TREATMENT
Strengths:
Level of insight:
Level of investment:
Level of agreeability to participate in structured unit milieu and engage in weekly individual and family therapy and psychiatric visits:

CLINICAL INFORMATION
Psychiatric and Developmental Diagnoses:
Service History:
Inpatient Hospitalizations: (please include approximate time frames)

RTF History: (please include approximate time frames and reason for discharge)	
Trauma History:	
Significant loss or grief:	
Recent changes (moving, divorce of parents, change in custody, recent diagnosis, parent recently incarcerated etc.):	
BEHAVIORAL	
NON SUICIDAL SELF-INJURY	
Current:	History:
Onset:	Frequency:
Type (i.e. cutting, scratching, ingesting foreign objects, head-banging, hair-pulling)	
Incidents of NSSI requiring more than first aid:	
Incidents of NSSI requiring restrictive procedures (therapeutic hold, seclusion, restraints):	

<table>
<tr><th colspan="2">PHYSICAL AGGRESSION</th></tr>
<tr><td>Current:</td><td>History:</td></tr>
<tr><td>Onset:</td><td>Frequency:</td></tr>
<tr><td colspan="2">Type (i.e. cutting, scratching, ingesting foreign objects, headbanging, hair pulling)</td></tr>
<tr><td>Targets:</td><td>Triggers:</td></tr>
<tr><td colspan="2">Incidents of aggression requiring restrictive procedures (therapeutic hold, seclusion, restraints)</td></tr>
<tr><td colspan="2"></td></tr>
<tr><th colspan="2">SEXUALIZED BEHAVIORS/BOUNDARIES</th></tr>
<tr><td colspan="2">History of poor boundaries (physical or relational) toward peers or staff?</td></tr>
<tr><td colspan="2">Has this patient ever been a no roommate?</td></tr>
</table>

History of Elopement:
History of psychosis, de-realization, depersonalization, disassociation:
History of paranoia:
History of substance abuse:
History of Psychogenic Non-Epileptic Seizure:
History of restrictive eating or purging:

PRTF USE ONLY
Approval or denial:
If approved, date of acceptance:
If denied, reason given:
Approximate admission date:
Follow-up: