Referral Information for Spring Harbor Developmental Disorders Program

Date: _____

Demographics

Referral Source Name/Agency: _____
Referral Source Phone Number: _____ Email Address: _____
Paperwork completed by: _____

Patient Name: _____ DOB:_____ Age:_____
SSN: _____-_____-_____ Sex: M / F Height: _____ Weight: _____
Home Address: _____
Home Phone #:_____Alternative phone #:_____
Living with (names):_____
Guardian (relationship):_____
Guardian Phone # (if different from above):_____
Emergency contact and phone #:_____
School Name: _____ Grade: _____
School address: _____
School contact and phone #:_____
Sending School district (if different from attending):_____

Interpreter / Accommodations needed? Yes No if yes, please explain: _____
_____

Insurance Information

Primary: _____ Policy #:_____
Ins. Address: _____
Phone #:_____ Group #:_____
Ins. Subscriber: _____ SSN: _____-_____-_____
Subscriber DOB: _____ Relation to patient: _____
Subscriber Address (if different from above):_____
Subscriber Employer and Address: _____

Secondary: _____ Policy #:_____
Ins. Address: _____
Phone #:_____ Group #:_____
Ins. subscriber: _____ SSN: _____-_____-_____
Subscriber DOB: _____ Relation to patient: _____
Subscriber Address (if different from above):_____
Subscriber Employer & Address: _____

Preferred names that your child goes by: _____
Does child have a current IEP and receive Special Education Services? Yes No

Clinical Information

Reason(s) for hospitalization: _____
_____

What do you think is causing the problems? _____
_____

What do you think would help your child's behavior? _____
_____

What are your goals for hospitalization? _____
_____

Have there been any recent changes/losses in the child's life at home/school? Yes No
If yes, please describe: _____
_____

What concerns you most about hospitalizing your child? _____
_____

Prior psychiatric hospitalization? Yes No If yes, where and when? _____
_____

Current Providers:

Psychiatrist:_____ Phone:_____
Pediatrician/Family Physician:_____ Phone:_____
Developmental Behavioral Pediatrician: _____ Phone:_____
Psychologist:_____ Phone:_____
Neurologist:_____ Phone:_____
Therapist:_____ Phone:_____
Community Case Manager: _____ Phone:_____
In-Home Supports Agency(s): _____ Phone: _____
_____ Phone: _____

List of *current medications*, dosage and time:

1._____ 5. _____
2._____ 6._____
3._____ 7. _____
4._____ 8._____

List of past medications and reason for discontinuing:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Any current over-the-counter or herbal remedies? Please list: _____
_____

Allergies to medication? Yes No If yes, please list: _____
Other allergies? Yes No If yes, please list: _____

Diagnoses:
AXIS 1: _____
AXIS 2: _____
AXIS 3:_____

Does child have a history of DRO (drug related organisms) such as MRSA or VRE? Yes No

Seizure Disorder? Yes No If yes, type: _____; Date of last seizure:_____

Other medical issues? 1. _____
2. _____
3. _____

Has your child received any psychological testing? Yes No With whom? _____
If known, **please specify IQ**: _____; Date of testing: _____

Communication: Your child's communication could be best described as: (please circle one)
Verbal Limited Verbal Non-verbal

On a scale of 0-5, *0 being no concerns, 5 being strong concerns*, how concerned are you about your child's ability to effectively communicate? Please circle: 0 1 2 3 4 5
no concerns strong concerns

Occupational Therapy:

Can child walk without assistance? Yes No If no, what type of assistance does he/she need? Wheelchair Gait belt Walker other_____

Does child have feeding or eating issues? Yes No Describe:_____
_____

Does child have a history of choking or aspirating? Yes No Describe: _____
_____

Self Care Skills: How much assistance does your child need?
Eating: Independent Minimal Assist Moderate Assist Total Assist
Dressing: Independent Minimal Assist Moderate Assist Total Assist
Toileting: Independent Minimal Assist Moderate Assist Total Assist

Behavioral Concerns:
Does your child have **aggression**? Yes No if so, please describe: _____
_____
How often? _____ Directed toward whom? _____
Most recent? _____ Does child punch with closed fists? Yes No
Has child ever required a physical restraint? Yes No If yes, please describe: _____
_____

Any history of **self-harming** behaviors? Yes No If yes, please describe: _____
_____

Any history of **sexualized behaviors** – including inappropriate touching, sexualized play, grooming or violence? Yes No If yes, please describe: _____
_____

Any history of **bolting or elopement**? Yes No

Does your child utilize any protective equipment? Yes No If yes, please describe: _____
_____

Does your child demonstrate any of the following? If yes, please describe:
Animal Cruelty Yes No _____
Fire Setting Yes No _____
Sexual perpetration Yes No _____
Homicidal ideation: Yes No If yes, please describe: _____
_____

Current or past suicidal ideation: Yes No If yes, please describe: _____
_____

History of experiencing physical/sexual trauma or exposure to domestic violence: Yes No
If yes, please describe: _____

Family psychiatric history: Yes No If yes, please describe: _____
_____

Discharge Planning

Is the plan that your child will return home? Yes No
If yes, what services will be needed to assist in the transition? _____
_____
If no, what alternative placement (e.g., residential) has been initiated? _____
_____

Please send the following information:

_____IEP/BIP (from school)
_____Psychological/neuropsychological evaluation
_____Psychiatric evaluation/notes/meds
_____Occupational therapy evaluation
_____Speech/language therapy evaluation
_____Vision and/or hearing evaluations
_____Behavior plan (past or current)

Any questions? Feel free to call Kate Hallissey at 207-661-6347.
Please fax all information to Kate Hallissey at 207-661-6089.