# EVALUATION/THERAPY INTAKE/REFERRAL FORM

***(Please complete FULLY and fax back with necessary documents to 212-420-1906 attention: Rivka/Pearl)***

**Referral Date:**_____ **Name of Individual:**_____ **Date of Birth:** ____/____/ _____
**Gender:** ☐**M** ☐**F** ☐**O** **Medicaid Number:**_____ **Social Security#:** _____-_____ -_____
**TABS ID:** _____**Parent/ Guardian Name:** _____
**Cell Phone:(____)_____-_____ preferred time to be called**_____ **Email:**_____
**Address:**_____**City:**_____ **Zip:** _____
**Lives with** ☐ **Own family** ☐ **In Group Home** ☐ **Other describe:**_____
**Current School/Day Program:**_____**Phone : (___)____-_____**
**School Address:**_____ **City:**_____**State:**_____ **Zip:**_____
**Referred by:**_____**Title/Rel. to Individual:**_____
**Referring Agency:**_____ **Phone #: (____)_____ Email:**_____
**Agency Address:**_____ **City:**_____ **State:**_____ **Zip:** _____

***Check All Services the individual/family is seeking at this time:*** ☐ Intake only ☐ HCBS Eligibility ☐ Psychiatric Eval ☐ Psychosocial Int. ☐ Psychological Evaluation ☐ Behavior Therapy **Counseling:** ☐ Individual ☐ Family ☐ Parent
**Groups**: ☐ Parent Support ☐ Social Skills ☐ Crisis Intervention **School aged child w/justification**: ☐O/T ☐ P/T ☐ Speech ☐ Other Service:_____
*If a specific evaluation(s) is needed please describe the reason:* (to apply for service(s)/program(s), updated evaluation etc.)
_____

***Describe any symptoms you are concerned about now:*** _____
_____

***Please check all Previous and/or Current Diagnoses:***

| | | | |
|---|---|---|---|
| ☐ Anxiety Disorder | ☐ Down Syndrome | ☐ Mood Disorder | ☐ Visual impairment |
| ☐ Attention Deficit/Hyperactivity Disorder | ☐ Eating Disorder | ☐ Neurological | ☐ Hearing impairment |
| ☐ Autism Spectrum Disorder | ☐ Intellectual Disability | ☐ Schizophrenia | ☐ Other: _____ |
| ☐ Depression | ☐ Learning Disability | ☐ Seizure Disorder | _____ |

*Please list all clinical and educational services being received at this time in any program* _____
_____
_____

*Describe any known trauma, confirmed or suspected abuse, hospitalizations, etc. (attach available info)*
_____
_____

***Family's Language:*** ☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Other:_____
***Individual's Language:*** ☐ No –Nonverbal or ☐ AAC ☐ Yes, in which language is he/she fluent ☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Other _____
***Translation required:*** ☐ No ☐ Yes If so, in what language or dialect _____
*****Note: Family members cannot translate during an evaluation. If needed a translator will be arranged. *****

**Required Documents:** To make a referral please fax this form with: a Current Medical (within 6 months) all previous evaluation(s) (Previous Educational Evals, or a referral from a physician) IEP, Medicaid/Health Insurance Card and Social Security Card. **For HCBS Services please attach the most recent CANS.**
***If any of these documents are not available –please explain or provide a statement from the parent or referral source.***

*If individual will not be accompanied by his/her Parent or Legal Guardian, formal consents must be requested in advance and signed prior to your appointment, and the Parent/Legal Guardian needs to be reachable by phone during the appointment time.*

***Do not write below this line:***

Initial Assessment(s) Scheduled Date:_____Time: _____with:_____
Initial Assessment(s) Scheduled Date:_____Time: _____with:_____
Any notes: _____