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: _____

Sex: ☐ M ☐ F ☐ Non-Binary Height: _____ Weight: _____

SSN: _____-_____-_____

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 choose 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 choose: ◯ 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:

Please select: ☐ 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)

Please send the following information where applicable: IEP, psychological evaluations, psychiatric notes, occupational therapy evaluations, speech/language therapy evaluations.

All information should be faxed to 207-553-8347. Please call 207-661-6347 with any questions.