

# REACHING YOUR GOALS, INC.

## Referral Application

<b>Client Name:</b>			<b>Medical Record #:</b>		
Nickname:			Race:		___ M ___ F
DOB:	Age:		Grade:	SSN:	
<b>Current Residence</b>					
Address:					
<b>Please indicate below with whom the child resides and their contact information:</b>					
<b>NAME</b>		<b>RELATIONSHIP</b>		<b>PHONE NUMBER(S)</b>	
If the child does not live with the birth family, is the birth family involved? ___ Yes ___ No If yes, please specify below:					
<b>NAME</b>		<b>RELATIONSHIP</b>		<b>PHONE NUMBER(S)</b>	
<b>List of Treatment Team Members</b>					
<b>NAME</b>		<b>TITLE</b>	<b>AGENCY</b>		<b>PHONE NUMBER(S)</b>
<b>DSM IV Diagnosis (please indicate Axis)</b>					
<b>Diagnosis</b>				<b>DSM Code</b>	
Axis					
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Axis				GAF:	

**Client Name:** \_\_\_\_\_ **Medical Record #:** \_\_\_\_\_

**Insurance Information**

Medicaid  IPRS  Health Choice  Other  Policy # \_\_\_\_\_

**MEDICATIONS**

Medication	Dosage	Prescribed By	Phone #	Compliance?

**PRECIPITATING EVENTS: Please describe why you are seeking Day Treatment for this client:**


**Does this client currently have an IEP?  Yes  No** **Is client currently on a  modified day or  home hospital**

**If yes to either, please describe current schedule:**

**Are you seeking the daytime (10-3) or afternoon (3:30-6:30) program for this client?  Daytime  Afternoon**

**Is client currently (or in last 6 months) a risk of self or others?  Yes  No** **If yes, please briefly describe:**


**Court Involvement?  Yes  No** **If yes, please briefly describe charges:**


**Current/Last School Attended:**

**Main #: \_\_\_\_\_ Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Phone #: \_\_\_\_\_**

**Is client currently attending school?  Yes  No** **If no, please explain:**


**Name of person completing this form:**

**Title: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_**

**Upon completion, fax to 919-832-6151 ATTN: Nicole Lowe**