PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR YOUTH AGES 6-17			
REFERRAL AGENT/AGENCY		DATE OF REFERRAL	
ADDRESS		TELEPHONE NUMBER	

YOUTH INFORMATION			
FIRST NAME		LAST NAME	
DATE OF BIRTH/AGE		GENDER/GENDER IDENTITY	
RACE/ETHNICITY		SPIRITUAL AFFILIATION	
INTERPRETER REQUIRED? LANGUAGE?		HEALTH CONCERNS OR PHYSICAL LIMITATIONS?	
GUARDIAN NAME GUARDIANSHIP PAPERWORK REQUIRED		COGNITIVE/DEVELOPMENTAL CONCERNS? MOST RECENT IQ?	
YOUTH ADOPTED? /AGE AT ADOPTION		ANY SCHOOL RELATED PROBLEMS?	
NAME OF SCHOOL/DISTRICT		CURRENT GRADE IEP? Y OR N	

PARENT/GUARDIAN INFORMATION			
NAME		PHONE	
ADDRESS		EMAIL	
ANY RESTRICTIONS WITH CUSTODY?		PARENTS OR GUARDIAN INVOLVED IN TREATMENT?	
EMERGENCY CONTACT		CONTACT NUMBER	

PRESENTING CONCERNS / COMMENTS Attach additional sheets and / or supporting documentation as deemed necessary.	
REASON FOR REFERRAL	
WHAT TREATMENT GOALS DO YOU HAVE? PARENT/YOUTH	
PSYCHIATRIC DIAGNOSIS (S)	

CAMBIA HILLS of East Bethel

SUICIDAL THOUGHTS/PLAN? HISTORY OF SUICIDE ATTEMPTS OR SELF HARM?	
ANY HISTORY OF ABUSE, NEGLECT OR TRAUMA?	
CHECMICAL ABUSE? LIST TREATMENT INTERVENTIONS	
CURRENT MEDICATIONS AND DOSES	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		MEMBER ID:	
GROUP NUMBER:		POLICY HOLDERS NAME	
POLICY HOLDER'S DOB:		RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE COMPANY:		MEMBER ID:	
GROUP NUMBER:		POLICY HOLDERS NAME	
POLICY HOLDER'S DOB:		RELATIONSHIP TO PATIENT	