



PHP Referral Form- Parent or Clinician

Today's date: _____ Referral source: _____

Patient's Demographic Information:

Patient's Name: _____ Patient's DOB: _____ Age: _____

Address: _____

Gender: M F Trans M Trans F Nonbinary

Race: American Indian Asian/Pacific Islander Black/African American White
 Other: _____ Prefer not to answer

Ethnicity: Hispanic Non-Hispanic

Patient's preferred language: English Spanish ASL Other: _____

Interpreter needed: Y N

Patient's current location: Home ED (where? _____) Inpatient (where? _____)

Parent/Guardian Information:

Primary Contact: _____ Relationship to patient: _____

Legal Custody: Married parents Mother Father (Married Y N)

Joint or Sole Custody? DCF Conservator: _____

Guardian: _____ Other: _____

Parent/Guardian's preferred language: English Spanish ASL Other: _____

Interpreter needed: Y N

FATHER: _____

Mailing Address (if different from patient):

Email address: _____

Preferred Phone #: _____ Type: C W H



MOTHER: _____

Mailing Address (if different from patient):

Email address: _____

Preferred Phone #: _____ Type: C W H

Secondary Contact: _____ Relationship: _____

Mailing Address: _____

Preferred Phone #: _____ Type: C W H

Insurance Information:

Primary Insurance: _____ ID #: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Patient Clinical Information:

Date of ASD diagnosis: _____ Name of clinician: _____

Diagnosed by: Birth-to-Three School Psychologist Psychiatrist/Neurologist
 Other: _____

Can provide report documenting Autism diagnosis with ADOS/CARS/GARS? Yes No

Additional diagnosis:

Intellectual Disability Down syndrome ADHD DMDD Anxiety
 Depression Reactive Attachment Disorder Other: _____

Grade: _____ School name: _____ School district: _____

Patient has: IEP 504 None Patient not attending school

Patient communicates via: Sentences Single Words Sign/gestures
 AAC device Other: _____

Does patient have any of the following impairments: Vision Hearing Mobility/Physical

Patient requires assistance with: Dressing Toileting Handwashing

What are the primary behavior problems? Aggression Verbal threats to others SIB
 Property destruction Suicidal ideation/attempts School refusal Sexualized behaviors
 Other (specify): _____

Does patient have any history of legal involvement? Arrest Probation Detention None

Legal contact if applicable: _____

Has patient ever been to the emergency room for his/her behavior?

Dates	Hospital	Reason	Outcome

Has patient ever been on an inpatient unit for his/her behavior?

Dates	Hospital	Reason	Outcome

Current medications

Medication	Start date	Dose/Schedule	Prescriber

Allergies? N Y: _____

Does patient have any major medical problems? Seizures Diabetes Asthma
 Other: _____



Current services:

	Name/Agency	Phone number
PCP/Pediatrician	_____	_____
Psychiatrist	_____	_____
Neurologist	_____	_____
ABA therapy at home	_____	_____
Individual therapist	_____	_____
DDS worker	_____	_____
DCF worker	_____	_____

(Voluntary Investigations Ongoing services)

Covid-19 Precautions

COVID-19 exposure screening

Will child wear a mask for program hours? Y N

Decision Point:

A) Appropriate for PHP admission: Y N Date reviewed with Medical Director: _____

Date of intake assessment: _____ Wait time quoted to referral source: _____

B) Needs higher level of care: Referral to AIU Referral to ED Referral to other hospital

C) Not appropriate for PHP admission: State reason: _____

Referral made (date and type of service): _____

Form completed by: _____

(print name/title)