LHBM Referral Form

Referral Date:

Referring Agency:

Staff Name:

Youth Name:

DOB:

Program: ☐ Full Day ($175) ☐ Half Day ($90)

Days: Wednesday

Minimum Attendance: 2 days/week

Medical & Emergency

Allergies:

Medications:

Safety Concerns:

Emergency Contact:

Behavior & Support

Acuity: Low

1:1 Needed:

Notes:

Consent

Signature:

Date: