STAR HEALTH REFERRAL FORM

Today's Date: _____ Name of Person Completing Form: _____

Relationship to Child: _____

TREATMENT SERVICES REQUESTED

Service(s): Psychological ____ Developmental ____ Pre-Adoption ____ CANS ____

CHILD'S INFORMATION

Child's Name: _____

Gender: M ____ F ____ Date of Birth: _____ SS#: _____

Medicaid #: _____

Location: Foster Home____ Kinship ____ Biological Family ____ Adoptive Family ____ CPS Office ____
Shelter (Name): _____ Detention Center (Location): _____

Caregivers: _____

Address: _____
Street Apt # City State Zip

Home Phone: _____ Cell: _____ E-Mail: _____

CHILD PROTECTIVE SERVICES INFORMATION

Caseworker's Name: _____ E-Mail: _____

Office Phone: _____ Cell: _____ Fax: _____

CHILD PLACING AGENCY or SHELTER INFORMATION

Agency/Shelter Name: _____ Case Manager: _____

Office Phone: _____ Cell: _____ Fax: _____

E-Mail Address: _____

CHILD'S NEEDS

Does child need an interpreter for a language besides English:? No ____ Yes ____- Language:_____

Does child have a hearing impairment that requires an interpreter? No ____ Yes _____

Does child have any other special needs? _____

Please check any of the following concerns prompting testing for the child:

___Anxiety	___Poor Social Skills	___Academic Problems
___Depression	___Eating Issues	___Behavior Problems at School
___Withdrawal	___Enuresis/Encopresis	___Attachment Difficulties
___Mood Instability	___Animal Aggression	___Sexual Behavioral Issues
___Anger Outbursts	___Destruction of Property	___Substance Abuse
___Hallucinations	___Inattention	___Illegal Behaviors
___Cognitive Deficits	___Speech Delays	___Threats to Harm Others
___Hyperactivity	___Self-Injurious Behaviors	___Pervasive Developmental Delays

Please provide any other information you think will be helpful: _____

_____

ASSESSMENT INFORMATION

Has the child had a previous assessment? No _____ Yes _____ if yes, Date Completed: _____

****Please note that STAR Health only allows an evaluation to be conducted on a calendar year basis. Therefore, testing can only be conducted after one year and one day from the date of a previous assessment.**

If you need a child evaluated prior to the one year allowance, please indicate the reason: _____

_____

Does the child need seen by a particular date? No _____ Yes _____ if yes, Date Needed: _____

Is the report needed by a particular date? No _____ Yes _____ if yes, Date Needed: _____

****Every effort will be made to accommodate the date(s) requested. You will be notified if the date(s) cannot be met or there is difficulty reaching a contact person for scheduling purposes.**

****Please include a copy of supporting documentation (i.e. affidavit of removal, previous testing, Form 2087, etc.) with the referral.**

CONSENT

YOUR SIGNATURE SERVES AS YOUR REQUEST FOR SERVICES AS THE CHILD'S LEGAL GUARDIAN. YOUR SIGNATURE CONFIRMS THAT YOU HAVE READ AND AGREE WITH THE INFORMATION IN THE CONSENT, HIPAA REGULATIONS, PROFESSIONAL DISCLOSURE, AND IF APPLICABLE, SPECIAL CONSIDERATIONS FOR TELEPSYCHOLOGY AND INFORMED CONSENT FOR TELEPSYCHOLOGY FORMS, PROVIDED WITH THIS REFERRAL FORM FOR YOUR REVIEW. PLEASE INSERT YOUR ELECTRONIC SIGNATURE BELOW, TO BE SIGNED AS "/first name and last name/" TO MAKE IT LEGAL (THE / BEFORE AND AFTER YOUR NAME MUST BE INCLUDED). YOU MAY ALSO PRINT THIS FORM, COMPLETE AND SIGN IT, AND EMAIL OR FAX IT DIRECTLY TO THE INFORMATION BELOW.

_____ _____

SIGNATURE **DATE**