Thrive Day Treatment

Therapeutic Care that Helps Kids Thrive

Referral Form

DATE OF REFERRAL

Once form is complete you should expect to hear from our team within 24-48hrs regarding next steps!

Program(s) of interest: ☐ Day Treatment/Academy ☐ Summer Therapeutic Program

CHILD'S INFORMATION

Child's Full Name :

Parent/Guardian Name:

Emergency Contact Name:

Child's Date of Birth :

Emergency Contact Phone:

Email :

Gender : ☐ Male ☐ Female

Phone:

Referral Source Name/Position:

Referral Email:

Referral Phone:

ADDRESS

Present Address :

City :

State :

Zip Code :

RELEVANT INFORMATION

School Currently Enrolled:

Current IEP? (Individual Educational Plan): ☐ Yes ☐ No

Primary Medical Provider:

Medicaid ID #:

Department of Juvenile Justice History? ☐ Yes ☐ No

☐ Please acknowledge that the parent/guardian source is the primary contact for proper communication and potential planning.

THANK YOU FOR YOUR REFERRAL!