# St. Joseph Orphanage - Referral Form

REVISED 08_2020

**Please return this form, along wth any supporting records/documentation to our Central Access Team.**

**Fax:** (513) 741-0875 **Email:** Admissions@SJOkids.org **Remote Phone:** (513) 334-6584 **Office Phone:** (513) 741-5690 x2214

- ☐ Outpatient Services
- ☐ Psychiatric Medication Management Services
- ☐ Assessment Services
- ☐ Education Services
- ☐ Day Treatment (K - 12)
- ☐ Substance Use Services
- ☐ Foster Care
- ☐ Independent Living Services
- ☐ Residential Interventions
- ☐ Intensive Home Based Treatment
- ☐ Partnering School - Day Treatment *(SchoolName):* _____
- ☐ Partnering School - Outpatient *(School Name):* _____

## Client's Information:

Name: _____ D.O.B: _____ Age: _____ Gender: _____
First Middle Last

Ethnicity: _____ Social Security Number: _____-_____-_____ Insurance Provider: _____ ID Number: _____

Phone Number: _____ Mobile ☐ Home ☐ Work ☐ Alternative Phone Number: _____ Mobile ☐ Home ☐ Work ☐

Address (city/state/zip): _____

Who has custody/guardianship of the youth? (*If Applicable*) _____ Relationship to the youth? *(If Applicable)* _____

Primary Language _____ Secondary Language _____ Is an interpreter needed for services provided in English? Yes ☐ No ☐

## Referral Information:

Person Making Referral: _____ Phone Number: _____ Fax #: _____

E-mail address: _____ Referring Agency: _____

## Reason for Referral/Presenting Problem:

## Other Agencies Currently Involved with Individual:

| Agency | Contact Person | Phone Number | Service Provided | Service will remain open (Y/N) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Significant Others in the Home:**

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

Name: _____ Relationship to client: _____

Age: _____

**Family Information** ***(For Youth Only)*****:**

Mother's Name: _____

Address: _____

Phone Number: (Home) _____ (Cell) _____

Father's Name: _____

Address: _____

Phone Number: (Home) _____ (Cell)

If we are unable to reach a parent, who can we call to assist us?

Name: _____ Phone: _____

Relationship (grandma, aunt, friend, etc): _____

**School Information** ***(For Youth Only)***

Name of School: _____

District of School: _____

Contact Person: _____Phone

Grade: _____ Is there a current I.E.P.? ____ yes ____ no

**Current Diagnosis:**

Source: _____ Date Given: _____

Please List Diagnosis:

_____

_____

_____

_____

_____

**Medical Information:**

Current Medication (s) and Dosage:

1. _____
2. _____
3. _____
4. _____

Prescribing Doctor/Psychiatrist: _____

Does the client have any Medical Concerns? Yes___ No___ (Explain Below)

Primary Care MD: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____