TENNYSON CENTER for CHILDREN

Client Name: _____

Client Date of Birth: _____

# REFERRAL FORM

Thank you for your interest in Tennyson's programs and services. **Please complete this form and email it to Tennyson at** admissions@tennysoncenter.org. We would appreciate it if you could also send any additional documentation that can help us determine if and how we can best support the person or family. Examples of documentation that could be helpful include **assessments, evaluations, discharge summaries, Individualized Education Plans (IEP), and/or Family Service Plan** (a copy of the student's IEP is required for all day treatment referrals). We will be in communication regarding the referral within one business day.

| **Referral Source Contact Information** | |
|---|---|
| Referring for: ☐ Day Treatment ☐ ASPEN Day Treatment ☐ Community-Based Services ☐ BRANCH<br>☐ Residential ☐ Outpatient Services ☐ Child First ☐ PCIT | |
| Funder for Services: | |
| Referring Agency: | Referral date: |
| Contact Name: | |
| Phone Number: | Email: |
| Is the client/family aware that a referral has been made to TCC? ☐ Yes ☐ No | |
| How did you hear about Tennyson Center? ☐ Current/Former Tennyson Client<br>☐ County Department of Human Services ☐ Hospital ☐ Insurance ☐ Previous experience with Tennyson<br>☐ School District ☐ Social media ☐ Tennyson Community Outreach Manager<br>☐ Tennyson Employee *name* _____ ☐ Other _____ | |

| **Client Information** | |
|---|---|
| Name: | |
| Address: | |
| Sex: _____ | Client Phone Number:<br>Client Email: |
| Legal Guardian(s) (*if applicable)*: | Relationship to Client: |
| Guardian's Address *(if different from above)*: | Phone number:<br>Email address: |
| Primary Language spoken in home: | |
| Therapeutic privilege (LAN) holder *(if applicable):* | Phone number:<br>Email: |
| Caseworker name *(if applicable):* | Phone number:<br>Email: |

| | |
|---|---|
| Guardian Ad Litem (GAL) name *(if applicable):* | Phone number: |
| | Email: |
| IEP?: ☐Yes ☐No | Current school: |
| Current grade: | |
| Primary Insurance Provider: | Policy Number: |
| Secondary Insurance Provider: | Policy Number: |

| **Health Information** |
|---|
| Mental Health Diagnoses *(if applicable)*: |
| Medical Conditions (for example, asthma, allergies, diabetes, seizures, dietary needs, etc.): |
| Is the individual currently on any medications? *(If so, please list name of medication, dose, dosing times,and prescribing physician)*<br>☐ Yes ☐No ☐ Unknown |

| **Family Information** |
|---|
| Has the individual experienced any trauma (for example, abuse, neglect, removal from home, inconsistent caregivers, traumatic incidents, etc.): |
| Cultural Considerations: |
| Safety concerns for staff going into the home (for example aggression towards staff, gang involvement, aggressive pets, weapons, etc.): |
| Please list individuals currently residing in client's home (and relationship to client): |

| Behavior/Symptom Information | | |
|---|---|---|
| **Behavior Concerns** | **Y/N** | **Details (severity, frequency, etc.)** |
| Depression | | |
| Anxiety | | |
| Verbal Aggression | | |
| Physical Aggression | | |
| Property Damage | | |
| Homicidal Ideation | | |
| Suicidal Ideation | | |
| Self-Harm | | |
| Sexualized Behaviors | | |
| Elopement/Running | | |
| Substance/Alcohol Use | | |
| Gang Involvement | | |
| Fire Setting | | |
| Animal Cruelty | | |
| School Truancy | | |
| Psychosis/Hallucinations | | |
| Cognitive Functioning | | |
| Developmental Delays | | |
| Enuresis/Encopresis | | |
| Hygiene | | |

Please share with us more information regarding the client and/or family system including why services are needed, strengths and interests, and desired outcomes from Tennyson services:

***Thank you again for your referral and we will be in communication in one business day!***