

Referral Form for Residential Treatment

McDowell Center for Children
711 Hwy 51 Bypass South
Dyersburg, Tn 38024
Phone # (731) 286-2861
ATTN: Tabitha Allen
Fax# (731) 286-2866
Email: Tabitha.allen@uhsinc.com

Date of Referral: _____

Referring Agency Contact Information:

Name/Agency: _____ Phone: _____

Client's Information:

Name: _____ Date of Birth: _____ Gender: ___ Male ___ Female

Social Security Number: _____ Race: _____ Phone: _____

Address: _____ City: _____ St: _____

Insurance: _____ Policy ID: _____

Parent/Guardian: _____ Relationship: _____

Phone Number: _____ Work Status: _____

Please answer the following questions about the client you are referring for an assessment:

1. What behaviors have the client presented that has lead him/her to residential treatment? (behaviors in the home, school, and community. Decrease in school grades/attendance. Physical aggression, sexual aggression/inappropriateness.) _____

2. Is the client currently taking any medications? If so what?

3. What services has client had in the past?

OP _____ Therapist _____

Start Date: _____ End Date: _____ Reason for treatment? _____

CCFT: _____ Case Worker: _____

Start Date: _____ End Date: _____ Reason for treatment? _____

Acute Care Stays: _____

If so, what were the dates and reason? _____

Legal Info:

Court Involvement? _____ If so, Probation Officer? _____

Legal Charges? _____ Upcoming Court Date? _____

Is client currently at risk for state custody? ____ YES ____ NO

Educational Info:

Current School Attending? _____ Grade: _____

Is client receiving special education? _____ Current IQ? _____

Current behaviors at school? Any problems with truancy or suspensions in the past year?

Please email or fax form requesting assessment and I will contact you as soon as I receive this.

Attn: Tabitha Allen

Fax# 731-286-2866 or Email: Tabitha.allen@uhsinc.com

Thank You for your referral.