EDGEWOOD
Transforming Lives. Restoring Hope.

Referral Form: Acute Intensive Services (SF)

CHILD INFORMATION					
Name				**DOB**	
Sex		**Identified Gender**		**Preferred Language**	

REFERRAL TYPE
Please check which program you are interested in referring your child to
☐Hospital Diversion ☐Partial Hospitalization Program ☐Intensive Outpatient Program

REFERRAL INFORMATION			
Name		**Relationship to Child**	
Phone #		**Email**	
☐	**Entered into Referral Tracker (For Edgewood staff use only)**		

INSURANCE INFORMATION	
Provider	
Insurance #	
Group #	
Edgewood advises you to check your behavioral/mental health policy and coverage prior to enrollment so that you understand what your benefit covers and for what, if any, copay and deductible you may be responsible. Edgewood will collect copay/deductible upon admission, if applicable.	

PARENT/ GUARDIAN INFORMATION		
Please indicate who has legal custody of child		
☐ Both Parents ☐ Mother	☐ Father ☐ Other relative	☐ Child Welfare Services ☐ Other:
Please note, if one parent has sole custody, upon admission Edgewood will need documentation verifying the custody agreement.		

Guardian 1		**Relationship**			
Phone #		**Email**			
Phone #					
Address					
	Street Address	City		State	Zip
Guardian 2		**Relationship**			
Phone #		**Email**			
Phone #					
Address					
	Street Address	City		State	Zip

REASON FOR REFERRAL	
☐ Depression	☐ Anger/ Aggression
☐ Anxiety	☐ Parent/ Child Conflict
☐ Suicidal thoughts	☐ Running away
☐ Self-injurious behavior	☐ Hallucinations
☐ Suicide Attempt	☐ Other:
Please elaborate on checked items (be sure to describe symptoms, behaviors, and his/ her present functioning:	

CURRENT PROVIDERS

☐ Check here if there are no current providers

Type		Name	Contact Info
☐	Therapist		
☐	Psychiatrist		
☐	Primary Care Physician		
☐	Other		
☐	Other		

HISTORY OF PSYCHIATRIC HOSPITALIZATION

☐ Check here if there is no history of psychiatric hospitalization

Dates	Hospital Name	Reason for Admission

CURRENT MEDICATIONS (psychotropic and OTC)

☐ Check here if there are no current medications

Medication	Dosage/ Frequency	Prescriber

DEVELOPMENTAL HISTORY
Any problems with pregnancy or birth of child? ☐ Yes ☐ No ☐ Unknown

Any significant problems with child's development (walking, eating, talking, toileting)? ☐ Yes ☐ No ☐ Unknown
If yes, please describe:

FAMILY
Who currently lives in the child's home?
Any family history of mental health/ substance abuse issues? ☐ No ☐ Unknown ☐ Yes, describe:
List any important family members currently not living in the home:

TRAUMA HISTORY ☐ Check here if there is no history of trauma		
☐ Physical Abuse ☐ Emotional Abuse	☐ Sexual Abuse ☐ History of Neglect	☐ Other trauma
If yes, please describe:		

SUBSTANCE USE ☐ Check here If there is no known history of substance use
Does the child have any history of drug or alcohol use? ☐ Yes ☐ Unknown
If yes, please describe:

MEDICAL ☐ Check here if there are no medical issues
Medical Issues:
Allergies (food, environmental or medication):

EDUCATIONAL INFORMATION			
School Name:		**School Location:**	
Grade:			
IEP	☐ Yes ☐ No ☐ Unknown		
If yes, IEP designation:	☐ Emotional Disturbance ☐ Other Health Impairment ☐ Speech/ Language Impairment ☐ Intellectual Disability ☐ Specific Learning Disability ☐ Other/ Unknown		

GOALS
Please identify goals for the child and family while receiving treatment at Edgewood

Once complete, please fax or scan this form via email to the member of the Intake Department with whom you initially made contact (Michael, Kelly, or Rachel). The fax number is 415-664-7094. Our intake team will review the information and determine if the child is an appropriate fit for these services. Once a decision has been made, a member of the intake team will contact you directly to discuss next steps.