Referral Information for CADD Day Treatment Program

Date Referral Information completed:_____

Demographics

Referral Source Name/School District:_____
Referral Source Phone Number:_____E-mail Address:_____

Student Name_____ DOB:_____ Age:_____
Preferred names that the child goes by:_____
SSN:_____-_____-_____ Sex: M / F Height: _____Weight: _____
Home Address_____
Home Phone#:_____ Alternative phone #_____
Living with:_____

Guardian (relationship):_____
Guardian Phone # (if different from above)_____
Emergency contact and phone #:_____
School Name:_____Grade:_____
School Address:_____
School Contact and Phone #:_____
Sending School District (if different from currently attending)_____

Does child have a current IEP and receive Special Education Services? Yes No

Insurance Information*

Primary:_____Policy#:_____
Ins Address:_____
Phone#:_____Group#:_____
Ins Subscriber:_____SSN_____-_____-_____
Subscriber DOB:_____ Relation to Student:_____
Subscriber Address (if different from above):_____
Subscriber Employer and Address:_____

Secondary:_____Policy#:_____
Ins Address:_____
Phone#:_____ Group#:_____
Ins subscriber:_____ SSN:_____-_____-_____
Subscriber DOB:_____ Relation to Student:_____
Subscriber Address (if different from above):_____
Subscriber Employer & Address (if different from above):_____

*Please note, the purpose of this information is, upon consent, your child's MaineCare will be billed for all clinical services provided as a day treatment student. Similarly, MaineCare requires all insurance information (including commercial insurance).

☐ I give consent to check the status of MaineCare benefits (please check box)

Clinical Information

Reason for out of district placement:

_____

_____

What are your goals of out of district placement?

_____

_____

Have there been any recent changes/losses in the student's life at home/school? Yes No

_____

_____

Has student had any prior out of district school placements? Yes No
If yes, where? When?

_____

Current Providers:

Psychiatrist:_____ Phone:_____
Pediatrician/Family Physician:_____ Phone:_____
Developmental Behavioral Pediatrician: _____ Phone:_____
Psychologist:_____ Phone:_____
Neurologist:_____ Phone:_____
Therapist:_____ Phone:_____
In-home agency: _____ Phone:_____

Medical History: Does the student have any medical problems or diagnoses?

1. 3.

2. 4.

Seizure Disorder: Yes No if yes, which type:_____

Can Student walk without assistance? Yes No
If no, what type of assistance does he/she need? Wheelchair Gaitbelt Walker other_____
Does the Student utilize any protective equipment? Yes No Describe_____

Feeding: Does Student have feeding issues? Yes No Describe:_____

_____

Does Student have a history of choking or aspirating? Yes No

Communication: Is the Student verbal? Yes No

If no, please circle communication used: PECS Communication Board Electronic Device ASL

Sign Language spoken/understood by Student: _____by Parent/Guardian:_____
Interpreter needed Yes No if yes, what type of services are needed?_____

Recent Speech/ Language Evaluation: Yes No if so, by whom and when?
_____

Occupational Therapy:
Does the Student have any sensory issues (i.e. food, clothing, loud noises etc..)? If so, please describe:_____

Recent Occupational Therapy evaluation? Yes No if so by whom and when:
_____

Behavioral Concerns:
Does Student currently engage in physical aggression? Yes No if so, please describe:
_____
_____
How often (frequency per day, week)?_____
Directed toward whom?_____
When was the most recent occurrence?_____
Does Student punch with closed fists? Yes No
Has Student ever required a physical restraint? Yes No if so, please describe:
_____
_____

Has the Student expressed any homicidal ideation: Yes No if yes, please describe:
_____

Has the Student expressed any current or past suicidal ideation: Yes No if yes, please describe:
_____
_____

Any history of running away? Yes No
Does the Student have a sense of safety awareness? Yes No

Does the Student have any history of self-harming behaviors? Yes No if yes, please describe:
_____
_____

Is there a history of "sexualized behaviors"- including inappropriate touching, sexualized play, grooming of others or violence? Yes No if so, please describe:
_____
_____

Does the Student demonstrate any of the following (If yes, please describe):
Animal Cruelty Yes No
Fire Setting Yes No
Sexual perpetration Yes No

History of experiencing physical/sexual trauma or exposure to domestic violence: Yes No
If yes, please describe:_____

Family psychiatric history:_____

Self Care Skills:

How much assistance does the Student need with:

Eating:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
Dressing:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
Toileting:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
ADL's:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist

Student's Leisure time:

How does the child like to spend his/her leisure time?

_____

Any transitional objects?_____Religious / Cultural beliefs:_____

Diagnoses:

AXIS I: _____

AXIS II: _____

AXIS III:_____

Recent psychological testing? Yes No if yes, where, when and by whom and IQ:

_____

Long-Term Goal:

Is the goal that the student will return to their local school setting? Yes No

If so, what assistance will be needed to assist in the transition?

_____

If no, what alternatives have been looked at/ what referrals were made?

_____

Please send the following information:

_____IEP (from school)
_____Psychological Testing (past three years)
_____Psychiatric Evaluation/Notes/Meds
_____Occupational Therapy Evaluation (most recent)
_____Speech/Language Evaluation (most recent)
_____Behavior Plan (past or current)
_____Most recent Vineland or ABAS adaptive scores.

Please fax all information to Steffanie Brackett, Psy.D. at 207-761-0784. Any questions or concerns please contact Dr. Brackett at 207-661-6702 or sbrackett@mainebehavioralhealthcare.org