

FAX this form anytime (secure, confidential 24/7) to: **610-383-1285**

FROM:	My Phone:	My Fax:
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Relationship to child being referred:	Date:
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Child's Name:	Social Security Number:
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Date of Birth:	Age:	Gender:	Pediatrician:
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Mother:	Work:	Home:
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Father:	Work:	Home:
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Child's mailing address:

Legal Custody:	Phone:
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Ethnicity:	Religion:	Primary Language:
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Primary health insurance and ID number:

PA MA ID #:

Office Use (EVS Date):

Reason for referral:

- Please check all that apply**
- | | | | | |
|--|---|--|---|-------------------------------------|
| Violence against adults <input type="checkbox"/> | Violence against peers <input type="checkbox"/> | Places self in danger <input type="checkbox"/> | | |
| DHS client <input type="checkbox"/> | Suicide attempt <input type="checkbox"/> | Mental Retardation <input type="checkbox"/> | School problems <input type="checkbox"/> | Drug abuse <input type="checkbox"/> |
| Alcohol abuse <input type="checkbox"/> | Autism or PDD <input type="checkbox"/> | Delinquency <input type="checkbox"/> | Currently in a hospital or Residential Treatment <input type="checkbox"/> | |

Current Medication & dosages and/or other health concerns:
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What phone number should we call, and when should we call you?
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