



NEXO Clinic Referral Form

CLIENT INFORMATION

Identified Child's Name:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Race:	Hispanic/Latino:	Family's Primary Language:
Mother's Name:	Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	DOB:
Full Address:	Phone and email:	
Father's Name:	Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	DOB:
Full Address:	Phone and email:	
School Name:	School Address:	Tel:
School Contact Name:	Contact email:	Tel:

BACKGROUND INFORMATION/CURRENT PLACEMENT

Does the child live with the parent(s)? Yes No

Does the child take psychotropic medication(s)? Yes No Name: _____ Dose: _____

Prescriber: _____

If no, adult responsible for the child's care: _____ Relationship: _____

Address: _____ Phone: _____

Any known/suspected safety concerns in the home? No Yes (please explain): _____

Any known/suspected safety concerns w/youth (e.g., weapons, gang, etc.)? No Yes (please explain): _____

Does the Child Have Insurance? Yes No

Name of Insurance: _____ **Policy Number:** _____

PRESENTATION & NEEDS (check all that apply)

<u>YOUTH</u>		<u>PARENT(S)/GUARDIAN(S)</u>
<input type="checkbox"/> Anger Control <input type="checkbox"/> Anxiety <input type="checkbox"/> Bullying (i.e. Victim / Aggressor) <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Daily Functioning/Self-Care Skills <input type="checkbox"/> Danger to Others (i.e. firesetting, homicidality) <input type="checkbox"/> Depression <input type="checkbox"/> Developmental/Cognitive Delays <input type="checkbox"/> Eating Disturbance <input type="checkbox"/> High Risk Sexual Behavior(s) <input type="checkbox"/> Impulsivity/Hyperactivity <input type="checkbox"/> Oppositional <input type="checkbox"/> Physical/Medical Needs	<input type="checkbox"/> Psychosis <input type="checkbox"/> Runaway /AWOL <input type="checkbox"/> School – (i.e. truancy, behavior) <input type="checkbox"/> Sexual Offending Behaviors <input type="checkbox"/> Sexually Reactive Behaviors <input type="checkbox"/> Social/Peer Relationship Functioning <input type="checkbox"/> Substance Use <input type="checkbox"/> Suicidal/Self-Injurious <input type="checkbox"/> Trauma: <input type="checkbox"/> Diagnos(es):	<input type="checkbox"/> Developmental/Cognitive Delays <input type="checkbox"/> Family Relationship(s) <input type="checkbox"/> Involvement/Engagement. w/Youth's Care <input type="checkbox"/> Mental Health Needs <input type="checkbox"/> Organization/Household Maintenance <input type="checkbox"/> Physical/Medical Needs <input type="checkbox"/> Residential Stability/Basic Needs <input type="checkbox"/> Safety & Abuse Concerns <input type="checkbox"/> Social Resources/Network <input type="checkbox"/> Substance Use <input type="checkbox"/> Supervision/Discipline Skills <input type="checkbox"/> Transportation <input type="checkbox"/> Diagnosis:

DESCRIPTION OF SERVICE NEEDS

REFERRAL SOURCE

Name:	Date:	Phone:
Name Of Person Filling Out The Referral:		