TIDES FAMILY SERVICES

WE NEVER GIVE UP ON A KID... NEVER!

Med Clinic Referral Form

CLIENT INFORMATION		
Client Name:	DOB:	Gender: ☐M ☐ F
Preferred Name & Pronouns:	Gender Identity (if different than above):	
Race:	Hispanic/Latino:	Primary Language:
Client Address:	Phone:	
	Email:	
School Name:	Phone:	
School Contact Name:	Email:	
Pediatrician:	Ped. Phone:	
Ped. Address:		
Insurance:	Insurance ID:	
Policy Holder Name:	Policy Holder DOB:	
Secondary Insurance:	Insurance ID:	
Policy Holder Name:	Policy Holder DOB:	
Social Security Number:		
FAMILY INFORMATION		
Parent 1 Name:	Legal Guardian? ☐ Yes ☐ No DOB:	
Address (if diff. than above):	Phone:	
	Email:	
Parent 2 Name:	Legal Guardian? ☐ Yes ☐ No DOB:	
Address (if diff. than above):	Phone:	
	Email:	
Legal Guardian (if diff than above):	Relationship:	
Address:	Phone:	
	Email:	
BACKGROUND INFORMATION/CURRENT PLACEMENT		
Does the child live with the parent(s)? ☐Yes ☐No		
If no, adult responsible for the child's care:	Relationship:	
Address:	Phone:	
	Email:	
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 take psychotropic medication(s)? ☐Yes ☐No ☐In the past		
RX Name & Dose:		
RX Name & Dose:		
RX Name & Dose:		
Prescriber:		

TREATMENT HISTORY (WITHIN PAST 18 MONTHS)			
Agency	**Service Type**	**Service Dates**	**Status/Reason for Discharge**

PRESENTATION & NEEDS (check all that apply)

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

DESCRIPTION OF SERVICE NEEDS

REFERRAL SOURCE

Name:	Phone:	Date:
Agency/Relationship:	Email:	

Please return completed referral to Dr. Eryn Yamin via:
Email at ***eyamin@tidesfs.org***
or
Fax at ***401-823-4694***