Referral Form

**Diversion Acute Stabilization (DAS)**

**Referral Date:**

**Check if youth has been a** **previous MHY Client**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: |  | **MA#:** |  |
| SS#: |  | DOB: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Other Insurance, if applicable: |  | Phone #: |  |
|  |  | Policy #: |  |

**Parent/Legal Guardian(s)**

If guardianship is split between two people or agencies please indicate

|  |  |  |  |
| --- | --- | --- | --- |
| Name(s): |  | Phone #: |  |
| Address: |  | Phone #: |  |
| Relation to Client: |  | Address #2 (if applicable) |  |
| County of Residence: |  |

**Provider making referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency: |  |
| Relationship to Client: |  | Phone #: **(direct line or extension)** |  |
| Fax #: |  |

**Youth’s presenting need for a DAS referral**

**Please be specific** on behaviors, who the behaviors are affecting, current mental health issues,

in-what settings youth is struggling, and so on. The more information the better – if more than the space provided below is needed, please include a typed up document with the information and simply state, “See attached document” below.

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**Current interventions being utilized to assist in stabilization**

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|  |

**DSM-5 Diagnosis (*Must include ICD-10 Codes*)**

|  |  |
| --- | --- |
| Psychiatric ***Primary*** Diagnosis:  ***Must include the***  ***ICD-10 Code*** |  |
| Additional Diagnoses **(Please Rank in order)**:  ***Must include the***  ***ICD-10 Codes*** |  |
| Medical Diagnoses: |  |
| Psychosocial Stressors: |  |

**IF CHILD HAS A DIAGNOSIS OF AUSTISM SPECTRUM DISORDER OR INTELLECTUAL DISABILITY**

**IQ (and please attach IEP):**

**Plan for Discharge**

|  |  |
| --- | --- |
| What residence will the client be discharged to upon discharge from the DAS program? |  |

**Current Medications and Dosages**

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| --- | --- |
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|  | |
| **If coming from the hospital** | |
| When was the last PRN? |  |
| What medication was used? |  |

**Medical Information**

Special needs, Medical issues, Allergies, Diet restrictions, etc.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
|  | | | |
|  | | | |
| Approximate Height: |  | Approximate Weight: |  |

**Educational Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contact Person  and Title: |  | Grade: |  | Current  Last Completed |
| School Name: |  | Phone #: |  | |
| District: |  | Fax #: |  | |
| Please check off the child’s educational status: | | Regular Education  Special Education | | |

**All Other Programs/Agencies *Currently* Involved**

(JPO/CYS, BHRS, FBMHS, SC, ETC.)

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Phone #: |  |
|  |  |
| Name: |  | Phone #: |  |
|  |  |
| Name: |  | Phone #: |  |
|  |  |

**Please List *Past* Services and Placements**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Service or Placement: |  | **Dates:** |  |
| **Phone #:** |  |
| **Fax #:** |  |
| Name of Service or Placement: |  | Dates: |  |
| Phone #: |  |
| Fax #: |  |
| Name of Service or Placement: |  | **Dates:** |  |
| **Phone #:** |  |
| **Fax #:** |  |
| Name of Service or Placement: |  | Dates: |  |
| Phone #: |  |
| Fax #: |  |

**CHECKLIST OF INFORMATION POSSIBLY NEEDED:**

Psychiatric Evaluation (within the past 6 months – IF AVAILABLE, NOT REQUIRED)

IQ if youth has an Intellectual Disability diagnosis

IEP and Neuropsych (if available) If youth has an Autism Spectrum Disorder diagnosis

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Print Name: |  |  |  |
| Signature: |  | Date: |  |

**Please fax, email, or direct referral questions to:**

Sarah Thomas, BS

Assistant Director, Admissions & Marketing

Phone: 724.625.3141 x252

Fax: 724.625.2226

[sthomas@mhyfamilyservices.org](mailto:sthomas@mhyfamilyservices.org)

**MHY FAMILY SERVICES**

**521 ROUTE 228**

**MARS, PA 16046**