Child Guidance Resource Centers

School Based Outpatient Referral Form

Fax Cover Page Check List

Fax Number: 484-454-8813

Attention: Joellen Corrocher (jcorrocher@cgrc.org / 484-454-8700 x1369)

Check List (make sure the following are included in the fax):

_____ Referral Form

_____ Release of Information

_____ School where services will occur: ____

_____ Name of person submitting referral: ____

_____ Email address of person submitting referral: _____________________________________

Notes

For CGRC Staff Use Only: (*check all that apply*)

☐Active/Internal Client ☐New Client ☐Open Access/Walk in
☐OPS ☐BHRS ☐BCM ☐FB
☐ PCIT ☐TF-CBT ☐PRT ☐IYS

CGRC REFERRAL FORM

Referral Information: (Parent / Guardian, PCP, MH Worker, School, Etc.)

Name of person making referral: ______________________________________Date:___________

Relationship to client: ____

Address/City/State/Zip: ____

Phone: ____

What service are you referring to?: ____

(Example: Outpatient Therapy, Case Management, BHRS)

Client Identifying Information:

Has client received prior services at CGRC? Yes/No Case#: _________________

If yes, date of discharge: ____________

Name (last, first, middle initial): ____

Address: ____

City / State / Zip: ____

County: ____

Primary phone: ____

Secondary phone: ____

SSN: ____

DOB: ____

Ethnicity: ____

Gender: M / F

School : __________________________________

Grade: ____

Verbal / Non Verbal

Primary Language: ____

Marital Status: Married Divorced Never Married

Employment Status: FT Student PT Student FT Employee PT Employee Other

Living Arrangement: Family Setting Foster Home Friend Group Home Homeless Other

Diagnosis:

Does client have siblings with services at CGRC? Yes / No

If Yes, please provide names of siblings and their staff: __________________________________

Legal Information / Primary Contact:

Is there a custody agreement in place? Yes / No

Name of person with legal custody: ____

Relationship to client: ____

Address/City/State/Zip: ____

Phone: ____
Employment phone: ____
Employment place: ____
Email address: ____

Secondary Contact in Case of Emergency:
Name: ____
Relationship to client: ____
Address/City/State/Zip: ____
Phone: ____

Client Insurance Information:
Does your child have Medical Assistance or an Access Card? Yes / No
If yes, please provide 10 digit State ID#: ___________________________
Does your child have a commercial insurance? Yes / No *If yes, please complete the following*:
Name of insurance plan: ____
ID#: ____
Policy Holder's Name: ____
Policy Holder's DOB: ____
Policy Holder's Employer's Name: ____
Phone# on back of insurance card: _______________________________________
Does your child have an Autism Spectrum Diagnosis? Yes / No
Is the insurance plan renewed in the Commonwealth? Yes / No
Are there 51 or more employees covered by the employer's health plan? Yes / No
Is it a self insured or self funded plan? Self Insured / Self Funded

Current Mental Health Treatment / Psychiatric Medications:
Current mental health services: ____
Psychiatric medication: ____
Safety Concerns
History of Domestic violence: Yes / No
Explain (between whom): ____
Is there a Protection From Abuse Order in place? : Yes / No
Courthouse PFA is filed with?: ____

Description of Current Concerns in different settings:
Home concerns:
____
School concerns:
____
Family needs:
____

Drug & Alcohol issues:

____

Social concerns:

____

Mental health concerns:

____

Medical concerns:

____

Placement / housing concerns:

____

Other:

____

At risk behaviors: Suicidal Homicidal Aggression Fire setting Self injurious behaviors

What type of therapist might work best with your child? (clinician preference):

____

When is your child most available to attend therapy sessions (days/hours/Saturdays)?

____

PLEASE NOTE: CGRC WILL MAKE EVERY EFFORT TO ACCOMMODATE YOUR PREFERENCES BASED ON CLIENT AND STAFF AVAILABILITY

For Outpatient Referrals Only:

Consent to treatment with a therapist in training/student intern: Yes / No

Requesting therapy at school: Yes / No If yes, school name: _________________________

CHILD GUIDANCE RESOURCE CENTERS
Authorization for Release of Information

Client Name: ______________________________ Medical Record #: ____________________

Address: ____

Social Security #: ______________________ Date of Birth: __________________________

Authorization:

I hereby authorize Child Guidance Resource Centers **to release and disclose** my treatment planning, medication information, progress, and treatment information by mail, email, courier, or fax:

FROM:
CHILD GUIDANCE RESOURCE CENTERS

2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

TO:
____

____

I hereby authorize Child Guidance Resource Centers **to obtain** my history and physical, medication information, immunization records, date of last physical examination information by mail, email, courier, or fax:

FROM:
____

____

TO:
CHILD GUIDANCE RESOURCE CENTERS

2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

Reason for disclosure:

referral continuity of care verbal communication parents records Other ____________________

Information to be disclosed: (Individual must check each appropriate section)

Mental Health **Yes** **No or Not Applicable**

Information released / obtained: Psychiatric/Psychological Evaluation(s), Biopsychosocial/Functional Behavior Assessment(s), Medical History, Medication Orders, Discharge Summary

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

Education Records **Yes** **No or Not Applicable**

Information released / obtained: IEP, ER, Report Card(s), Daily Academic and Behavioral Goal Sheets, Behavior Plans, School Observations, Attendance, Disciplinary Records, On-going verbal communication

This information will be disclosed from records protected by Pennsylvania State law and the Family Educational Rights and Privacy Act of 1974.

Drug & Alcohol **Yes** **No or Not Applicable**

Information released / obtained: Dates of Service, Prognosis, Treatment Recommendations, Relapse

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual or organization identified on this form from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV **Yes** **No or Not Applicable**

Information released / obtained: Coordination of Care / Clinical Profile

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

Demographic information **Yes** **No or Not Applicable**

Specifically: ____

This authorization expires as indicated: From ____________________ to ________________ (not to exceed one year).

I understand that:

- This consent is voluntary. I may refuse to sign this form.
- This authorization may be revoked at any time in writing to the individual / organization identified in this authorization except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- CGRC, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- None of the information released will be used to support any criminal charges or conduct an investigation of me, without a court order.
- If I do not sign this form my treatment team may not receive information that could be important to my treatment.
- If I do not sign this form a delay in treatment or an unknown impact on treatment and care could result.

Authorized Signature(s):

____________________________________ ____________________
Client Signature (if 14 years of age or older) Date

____________________________________ ____________________
Parent / Legal Guardian Signature Date

FOR DRUG AND ALCOHOL TREATMENT PARENT / LEGAL GUARDIAN SIGNATURE IS NOT APPLICABLE UNDER ACT 63

____________________________________ ____________________
Witness Signature Date

If individual is physically unable to sign, signature of second witness: ____________________________________

THIS AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS ARE COMPLETED