

**Children's Choice Respite & PRP Program
230 Florida Avenue
Salisbury, MD 21801
410-860-0484**

Referral Information Needed From Referring Agency

A complete referral will include:

- **DSM IV diagnosis**
 - **Individual who diagnosed the child**
 - **Date child was diagnosed**
- **Name and telephone number of current psychologist/psychiatrist**
- **Treatment modality and frequency**
- **Current medications**
- **Family history**
- **Any history related to current need for respite**
- **Copy of the child's ITP/IRP**

Children's Choice Respite
Referral Form

Referred by: _____ Phone: _____

Please Circle One of the Following:

Parent Therapist Psychiatrist Other: _____

Client Information

Name: _____ Phone: _____

Address: _____ SS#: _____

_____ DOB: _____

Gender: M F Race: W B H O Age: _____

Insurance: _____ Insurance #: _____

Caretaker: _____ Relationship: _____

Household Members: _____

Diagnosis & Code: (attach a copy of ITP/IRP)

AxisI: _____

AxisII: _____

AxisIII: _____

AxisIV: _____

AxisV: _____

Date of dx & who diagnosed: _____

Current Need for Respite: (Precipitating Events)

Mental Health TX Provider

Agency: _____ Therapist: _____

Address: _____ Phone: _____

Medication (List): Compliant? Y N

Current Treatment: (modality and frequency)

Treatment HX: (hospitalizations / other agencies / etc)

Firesetting Y N (explain)

Sexual Acting Out: Y N (explain)

Substance Abuse: Y N (explain)

Suicidal / Homicidal Ideation: Y N (explain)

School Problems: (HX)

Family HX: (Mental Health/AOD Abuse/TX)

Signature: _____ Date: _____