

Service Requested:			Date of Referral:		
Referral Source Name:		Relationship to Applicant:		Referral Source Phone:	
Name:		DOB:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T	Primary Language:	Last 4 SSN (DDS ONLY):
Physical Address of Person:			City/Town:		State:
Zip:	Current Living Situation	<input type="checkbox"/> Home	<input type="checkbox"/> Friends	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Shelter/Assessment
<input type="checkbox"/> Relative	<input type="checkbox"/> Homeless	<input type="checkbox"/> Group Care	<input type="checkbox"/> Detention/Secure (DYS)	<input type="checkbox"/> Jail/Lock-up	<input type="checkbox"/> Psych Hospital
<input type="checkbox"/> Medical Hospital	<input type="checkbox"/> Unknown	Current diagnosis:			
Primary Phone:		Alternate:		Race: <input type="checkbox"/> Multi- Racial <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> Black (non-Hispanic)	
Primary Email:				<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American	
Ethnicity	<input type="checkbox"/> African	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Dominican	<input type="checkbox"/> Haitian	<input type="checkbox"/> Mexican
<input type="checkbox"/> African American	<input type="checkbox"/> Cape Verdean	<input type="checkbox"/> Cuban	<input type="checkbox"/> Jamaican	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> South American
<input type="checkbox"/> Asian Indian/Pakistani	<input type="checkbox"/> Central American	<input type="checkbox"/> Eastern Europe	<input type="checkbox"/> Japanese	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Uruguayan
<input type="checkbox"/> Brazilian	<input type="checkbox"/> Chinese	<input type="checkbox"/> European	<input type="checkbox"/> Laotian	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> West Indian
<input type="checkbox"/> Other (describe)	Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Insurance:			Policy #:		
Secondary Insurance:			Policy #:		
Number of units authorized:			If DMH, has PDI been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Person financially responsible for this applicant: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other:					
Case Worker Name:			Phone Number: Phone:		
Person to contact for appointment:		Relationship to Client:		Phone:	
If Person under 18: Caregiver 1 Name: Caregiver's Primary Language: Will they be involved in treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Address: <input type="checkbox"/> Same <input type="checkbox"/> Other: Primary Phone: Email: Alternate:			If Person under 18: Caregiver 2 Name: Caregiver's Primary Language: Will they be involved in treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Address: <input type="checkbox"/> Same <input type="checkbox"/> Other: Primary Phone: Email: Alternate:		
Does caregiver have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, Guardian Name: Phone Number:		Relationship:	
Gender Preference for LUK Staff: Female Male No Preference <input type="checkbox"/> Request Specific Staff: _____					
<input type="checkbox"/> Available Most Days and Times <input type="checkbox"/> Preferred Time, Day & Location:					
Brief Description of Needs Requiring Service:					

Where Do the Needs Impact Functioning? <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Other _____					
Client's Strengths (Social, Interpersonal, Personal care, Behavioral, Academic, Arts/Sports/Recreational etc.):					

Current Reactions/Behaviors/Functioning (Check all that Apply): <input type="checkbox"/> Aggression <input type="checkbox"/> Anxiety <input type="checkbox"/> Attachment Difficulties					
<input type="checkbox"/> Attention/ Concentration <input type="checkbox"/> Conduct Problems <input type="checkbox"/> Depression <input type="checkbox"/> Dissociation <input type="checkbox"/> Impulsivity <input type="checkbox"/> Oppositional Behaviors					
<input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Problems with Emotional Regulation <input type="checkbox"/> Reactive to Trauma Reminders <input type="checkbox"/> Self-Harm					
<input type="checkbox"/> Somatization/Physical Complaints <input type="checkbox"/> Substance Use <input type="checkbox"/> Severe Allergies <input type="checkbox"/> Other _____					
In order to help link the person to the best service we need to ask a few additional questions.					
Do you know of any really scary or upsetting thing that happened to the (your) child or (your) the child's family in their lifetime? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Is Person the victim or family member of a DUI? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Is the person a military member, veteran, or family member? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe who:					
Are there any factors that will impact the person's ability to attend face-to-face appointments in one of LUK's facilities?					
<input type="checkbox"/> No <input type="checkbox"/> Transportation <input type="checkbox"/> Child Care <input type="checkbox"/> Disability <input type="checkbox"/> Financial Hardship <input type="checkbox"/> Other _____					
Other Provider:		Role:		Phone:	
Other Provider:		Role:		Phone:	
CALL: Toll-Free: 800-579-0000 Direct Line: 978-829-2222 All referral materials can be sent to: Email: referrals@luk.org Fax: 978-829-2250					