LUK, Inc. Central Referral 978-829-2222

Service Referral Form

Service Requested:	Date of Referral:

Referral Source Name:	Relationship to Applicant:	Referral Source Phone:

Name:	DOB:	☐ M ☐ F ☐ T	Primary Language:	Last 4 SSN (DDS ONLY):

Physical Address of Person:	City/Town:	State:	Zip:

Current Living Situation ☐Home ☐Relative ☐Friends ☐Homeless ☐Foster Care ☐Group Care ☐Shelter/Assessment ☐Detention/Secure (DYS) ☐Jail/Lock-up ☐Psych Hospital ☐Medical Hospital ☐Unknown

Current diagnosis:

Primary Phone:
Primary Email:

Alternate:

Race: ☐ Multi- Racial ☐White (non-Hispanic) ☐ Black (non-Hispanic) ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Native American

Ethnicity ☐ African ☐ African American ☐ Asian Indian/Pakistani ☐ Brazilian ☐ Cambodian ☐ Cape Verdean ☐ Central American ☐ Chinese ☐ Dominican ☐ Cuban ☐ Eastern Europe ☐ European ☐ Haitian ☐ Jamaican ☐ Japanese ☐ Laotian ☐ Mexican ☐ Middle Eastern ☐ Portuguese ☐ Puerto Rican ☐ South American ☐ Uruguayan ☐ Vietnamese ☐West Indian ☐ Other (describe)

Translator needed? ☐ Yes ☐ No

Primary Insurance:	Policy #:
Secondary Insurance:	Policy #:

Number of units authorized: If DMH, has PDI been completed? ☐ Yes ☐ No

Person financially responsible for this applicant: ☐ Self ☐ Parent/Guardian ☐ 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 ☐ Yes ☐ No
Address: ☐ Same ☐ Other:
Primary Phone: Email:
Alternate:

If Person under 18: Caregiver 2 Name:
Caregiver's Primary Language:
Will they be involved in treatment ☐ Yes ☐ No
Address: ☐ Same ☐ Other:
Primary Phone: Email:
Alternate:

Does caregiver have legal custody? ☐ Yes ☐ No
If no, Guardian Name: Relationship:
Phone Number:

Gender Preference for LUK Staff: Female Male No Preference ☐ **Request Specific Staff:** ____________________
☐ Available Most Days and Times ☐ Preferred Time, Day & Location: ____________________

***Brief Description of Needs Requiring Service*:**

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Where Do the Needs Impact Functioning? ☐ Home ☐ School ☐ Community ☐ Other ____________________

Client's Strengths (Social, Interpersonal, Personal care, Behavioral, Academic, Arts/Sports/Recreational etc.):

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Current Reactions/Behaviors/Functioning (Check all that Apply): ☐ Aggression ☐ Anxiety ☐ Attachment Difficulties ☐ Attention/ Concentration ☐ Conduct Problems ☐ Depression ☐ Dissociation ☐ Impulsivity ☐ Oppositional Behaviors ☐ Physical Disabilities ☐ Problems with Emotional Regulation ☐ Reactive to Trauma Reminders ☐ Self-Harm ☐ Somatization/Physical Complaints ☐ Substance Use ☐ Severe Allergies ☐ 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?
☐ YES ☐ NO

Is Person the victim or family member of a DUI? ☐ YES ☐ NO
Is the person a military member, veteran, or family member?☐ YES ☐ 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?
☐No ☐Transportation ☐Child Care ☐Disability ☐ Financial Hardship ☐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