|  |  |
| --- | --- |
| 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 | **If Person under 18:** Caregiver 2 Name:      Caregiver’s Primary Language:      Will they be involved in treatment [ ]  Yes [ ]  No |
| Address: [ ]  Same [ ]  Other:       | Address: [ ]  Same [ ]  Other:       |
| Primary Phone: (     )      -     , Email      Alternate: (     )      -      | 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*:**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Where Do the Needs Impact Functioning?*** [ ]  Home [ ]  School [ ]  Community [ ]  Other     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Client’s Strengths (Social, Interpersonal, Personal care, Behavioral, Academic, Arts/Sports/Recreational etc.):***      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***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 [ ]  NOIs the person a military member, veteran, or family member?[ ]  YES [ ]  NOIf 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  |