TIME Family Services, LLC
fax – 888.709.1905
www. TIME 4Family.net

Gloria Setterlund LPC CSOTP – Clinical Director
434.989.3579
George Szabad – Program Director
540.223.3836

PLEASE PRINT or TYPE

Child's Name:		**SS#:**		**Sex:**	
Case/Record# (if applicable):	**N/A**	**DOB:**		**Race:**	

Referral Form for Intensive Mental Health Services for Children

Application for: __ Intensive In-Home Child Mentoring ____ Intensive In-Home Child/Family Therapy
__ Group Therapy

Client Information

Client Name: _____ **Application Date**: _____
Last First MI

DOB: _____ Age:_____ Sex : __Male __Female SSN: _____

Ethnicity (optional): _____ Primary Language (optional): _____
Address:_____
City: _____ State: _____ Zip:_____

Custody / Living Arrangements:
In legal custody of: _____
Address:_____
City: _____ State: _____ Zip:_____
Home phone: _____
Work phone: _____

Custody status:
__Biological parents __ Adoptive parents __ Other family or legal guardian ____ DSS
__ Correctional Facility __ Emancipated minor __Other_____

If not living with legal custodian, where is the child currently living?
Name:_____
Address:_____
City:_____ State: _____ Zip:_____

Relationship to child:_____

If currently in a residential or foster care placement, what is the discharge plan?
Discharge date: _____
To what setting?_____
Other services involved in discharge plan:_____

Other contact: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____

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Funding Eligibility

Medicaid:		Title IV-E:		CSA:		Adoption Subsidy		HMO	

Medical/Medicaid Insurance No.:		Social Security No.:	

Referral Information

Person making the referral (name & title_____
_____
Representing which agency / committee_____
_____
Address:_____
_____
City: _____
State:_____ Zip:_____
Phone: _____ Fax:_____ Email: _____
_____
Relationship to client:_____

Mental Health Information

Most recent DSM IV diagnosis: Date: _____ By whom?_____
(Use words, not code numbers.)

Axis I:

Axis II:

Axis III (Medical conditions):

Axis IV(Environmental stresses):

Axis V (Current Global Assessment of Functioning): _____ GAF (Highest level in past year):_____

Reason for Referral:

PLEASE PRINT or TYPE

Child's Name:		SS#:		Sex:	
Case/Record# (if applicable):	N/A	DOB:		Race:	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to parents / those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain)					
Other (explain)					

PLEASE PRINT or TYPE

Child's Name:		**SS#:**		**Sex:**	
Case/Record# (if applicable):	**N/A**	**DOB:**		**Race:**	

Medical Information

Medical problems:

Current medications:

History of medical care:

Print Name of Applicant_____Phone_____

Relationship to Child_____

Organization/Agency_____ Position _____

Signature

_____

Parent/Guardian Signature (required)_____

Do not write in this box. TIME use only:

Name of Screener:	**Method of Screening:**
Recommendation:	**Disposition of individual:**

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Child's Name:		**SS#:**		**Sex:**	
Case/Record# (if applicable):	**N/A**	**DOB:**		**Race:**	

Client Name:_____DOB:_____

I _____ hereby authorize
TIME Family Services, LLC, 33011 Indiantown Road, Locust Grove VA 22508

☐To Release Verbal / Written Information to: ☐To Obtain Verbal / Written Information from:

AGENCY NAME:_____
ADDRESS:_____
_____

The type of information to be disclosed is:

☐ Admission / Discharge Summary
☐ Psychosocial Evaluations
☐ Psychological Evaluations
☐ Psychiatric Evaluations
☐ Psychosexual Evaluations
☐ Progress Summaries
☐ Medication History
☐ MRI / Neurology Evaluations
☐ Court/Probation
☐ Other: ___

The purpose of this information disclosure is to assist in completion of Child Mental Health evaluation(s), treatment recommendations, and /or placement.

This authorization is valid until: _____Six months from the date of signature.
_____The following event or date, not to exceed one (1) year.

This consent may be revoked at any time, except to the extent that action has been taken in reliance on it. The person completing this form has a right to receive a copy. This form is invalid unless all sections are completed. Do not sign this form unless a specific request has been made and the request is in your child's best interest.

_____ _____
Client Signature (If applicable) Date Print Name

_____ _____
Parent, Guardian, Custodian Signature (Circle one) Date Print Name

This information has been disclosed from records whose confidentiality is protected by federal and state law. Any further disclosure is prohibited without the specific written consent of the person to whom it pertains, or as otherwise permitted by federal or state regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.