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| um_childrens_pms | The Care Clinic520 W. Lombard St, Gray Hall, Ground FloorBaltimore, MD 21201 |
|  Adult Referral FormDemographic Information

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| **Name**:Click or tap here to enter text. | Birth DateClick or tap to enter a date. |
| Race/Ethnicity:Choose an item. | Gender:Choose an item. |
| Address: Click or tap here to enter text. | City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip code: Click or tap here to enter text. |
| Primary phone: Click or tap here to enter text.Type: Choose an item.  | Secondary phone: Click or tap here to enter text.Type: Choose an item.  | Email: Click or tap here to enter text. |
| Do any of the following apply to this child? (check all that apply)[ ] Deaf/hard of hearing [ ] Homeless [ ] Immigrant/refugee/asylum-seeker [ ] LGBTQ [ ] Veteran [ ] Limited English/ESL [ ] Disability (physical/cognitive/mental) [ ] Other:  |

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| **Household Members**  |
| Name | Age | Relationship to client (e.g., child, partner, friend, etc.) |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **Worker’s Name** (i.e., DSS, DJS, etc.): Click or tap here to enter text. | Phone number: Click or tap here to enter text. |
| Worker’s Supervisor’s Name: Click or tap here to enter text. | Phone Number: Click or tap here to enter text. |
| Street address: Click or tap here to enter text. | City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip code: Click or tap here to enter text. |
| **Primary Care Physician/Practice Name:** Click or tap here to enter text. | Phone number: Click or tap here to enter text. |
| Street address: Click or tap here to enter text. | City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip code: Click or tap here to enter text. |
| **Employer Name:** Click or tap here to enter text. | Position: Click or tap here to enter text. |
| Work Schedule: Click or tap here to enter text. |

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**Referral Information**

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| **Date of Referral**: Click or tap to enter a date. |  |
| Primary and Secondary Victims (and DOB): Click or tap here to enter text. |
| **Referral Source: Name & Agency** Click or tap here to enter text. | Email:: Click or tap here to enter text. |
| Address: Click or tap here to enter text. | City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip code: Click or tap here to enter text. |
| Primary phone: Click or tap here to enter text.Type: Choose an item.  | Secondary phone: Click or tap here to enter text.Type: Choose an item.  | Fax: Click or tap here to enter text. |

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| **Types of Abuse**: (check all that apply) | **Perpetrator**:(Name and relationship)And basic description | **Date of Abuse** (or timeframe) | **Date of Disclosure** |
| [ ] Physical Abuse  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| [ ] Sexual Abuse  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| [ ] Sex Trafficking  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| [ ] Neglect  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| [ ] Intimate Partner Violence | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Reason for Referral:** (brief summary of the abuse and observed behavioral problems or symptoms) Click or tap here to enter text. |
| **Symptoms: (mark all that apply)**[ ]  Fire setting [ ]  Abuse of animals [ ]  Psychiatric hospitalizations[ ]  Suicidal gestures or ideation [ ]  Violence toward others [ ]  Speech/developmental delays[ ]  Psychosis [ ]  Sexual behavioral concerns [ ]  Physical aggression [ ]  Drug/alcohol abuse [ ]  Sleep problems [ ]  Nightmares/flashbacks[ ]  Hallucinations [ ]  Tantrums [ ]  Academic/school problems[ ]  Anxiety [ ]  Depression [ ]  Irritability[ ]  Disordered eating [ ]  Low self-esteem [ ]  Mood fluctuation **Description:** Click or tap here to enter text. |
|  |
| **Medical Issues and Medications:** Click or tap here to enter text. | **Other** **Service or Supports**: (work program, TCA, or other services): Click or tap here to enter text. |
| **Current Treatment**: Is the adult currently in treatment?Choose an item.If so, where and reason for treatment?Click or tap here to enter text. |
| **Care Clinic Services Requested** (mark all that apply):[ ]  Intake Evaluation (diagnosis, treatment recommendations) [ ]  Individual Therapy [ ]  Group Therapy [ ]  Family/Couple Therapy[ ]  Psychological Evaluation (for academic/cognitive functioning) [ ]  Psychiatric Evaluation **(only for care clinic clients)****Please note preference for in-person or telehealth:**[ ]  In-person [ ]  Telehealth [ ]  Either/both**\*The Care Clinic does NOT provide forensic assessments.** |