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| um_childrens_pms | The Care Clinic 520 W. Lombard St, Gray Hall, Ground Floor  Baltimore, MD 21201 |
| Adult Referral Form Demographic Information   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **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: | | | | | | |  |  |  |  | | --- | --- | --- | | **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. | | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |  |  |  |  |  | | --- | --- | --- | --- | | **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. | | | | |
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| **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.** | | | | | |