

Please fax completed referral form to the FCDC intake line
at: 412.347.3237



BHRS Referral Form

Date completed: _____

Referral Source: _____

Location

North Hills Penn Hills South Hills Butler

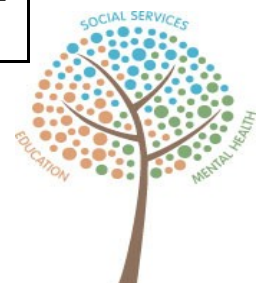
Client Information

Child's name:	_____					
MA #	_____	DOB	_____	Age	_____	
Social Security #	_____					
Parent/Caregivers names:	_____					
Home address:	_____					
Residing county:	<input type="checkbox"/> Allegheny	<input type="checkbox"/> Butler	<input type="checkbox"/> Washington	<input type="checkbox"/> Westmoreland	<input type="checkbox"/> Armstrong	<input type="checkbox"/> Beaver
Home phone:	_____	Alt. phone:	_____			
E-mail address:	_____					
Race:	_____	Religion:	_____	Language:	_____	
Service coordinator:	_____					
Contact number:	_____	Agency:	_____			
VBH County Rep:	_____					

Prescriber Information

Prescribing Psychologist:	_____
Primary diagnosis:	_____
BHRS prescription:	_____

What are the presenting behaviors? _____





School Information

Residing school district: _____

School: _____

Grade: _____

IEP: ____ yes ____ no **District:** _____

Contact person: _____ **Phone:** _____

What services has your child received/does receive?

Current

Service: _____	Agency: _____
Contact person: _____	Phone: _____
Service: _____	Agency: _____
Contact person: _____	Phone: _____
Service: _____	Agency: _____
Contact person: _____	Phone: _____

History

Service: _____	Agency: _____
Service: _____	Agency: _____
Service: _____	Agency: _____

Staff Schedule

Mon: _____

Tues: _____

Wed: _____

Thurs: _____

Fri: _____

Sat: _____

Notes: _____

