Northwest Journey
Referral Form / Pre-Mental Status Exam Information Sheet.

Date: _____
Referring Party Name: _____
Who referred you to Northwest Journey? _____

Identifying Data
Child's Full Name: _____
Child's Date of Birth: _____ Race: _____
Age: _____ Gender: ☐Male ☐Female
Address: _____
County: _____
Phone: _____ Fax: _____
Other: _____
Child lives with: _____
Who has legal custody: _____

Parent/Guardian Name(s): _____
Address: _____

_____
Phone: _____ Fax: _____
Other: _____
Are biological parents involved with child?: _____
If not, when was last contact?: _____

Funding Source
☐Medical Assistance (need MA number): _____
☐Private Insurance (Need: Insurance name, primary insurance holder, primary's DOB, SS#, Subscriber #, Group #, and phone # on card): _____

_____

_____
Other back up funding source: _____

Referral Information
Why is the child being referred? What are his/her needs? _____

_____

_____

_____

_____

_____
How long has the child had these problems? _____

_____
Has the child received or is she/he currently receiving mental health services? Please provide list.

_____

_____
Does the child have a psychiatrist? If no, an appointment must be scheduled ASAP. If yes, when is the next psychiatric visit scheduled? _____

Has the child had a physical with an MD? If yes, when? If no, please schedule ASAP. _____

Is the child currently taking medications? Would they need to be distributed at Northwest Journey?

Does the child have a mental health diagnosis? (please list, including who made the diagnosis and when): _____

Are all providers in support of the referral? _____

SED Criteria (Must have at least 1 symptom and/or 2 functional impairments):

- ☐ Psychotic Symptoms
- ☐ Suicidality
- ☐ Violence
- ☐ Self-care functioning impairment
- ☐ Social relationship functioning impairment
- ☐ Community functioning impairment
- ☐ School functioning impairment
- ☐ Family functioning impairment

Services received and dates of service:

- ☐ Juvenile Justice __/__/__ to__/__/__
- ☐ Child Protection __/__/__ to__/__/__
- ☐ Social Services __/__/__ to__/__/__
- ☐ Special Education __/__/__ to__/__/__
- ☐ Mental Health __/__/__ to__/__/__
- ☐ Psychiatry __/__/__ to__/__/__

Previous or Current Services (obtain releases)
(School, MH providers, Human Services, Sheriff's Dept., Insurance Company, Primary Physician, Psychiatrist, In-home, guardian's significant other, etc.)

Facility Name and type of service	Address	Phone & E-mail	Contact Person/Provider