Friendship Academy Referral Form

Please complete referral form and required documents below and email to:
jsnow@thewatsoninstitute-fa.org or Fax to: 412-361-6775
Please Note: Partial Hospital Treatment is funded through Medical Assistance.

Required Documents:

- Current IEP
- Current Evaluation/Reevaluation Report
- Current psychiatric information, if applicable (ex. discharge summary, progress reports, psychiatric evaluations etc.)

Child/Adolescent Referral Information

Name: _____ DOB: _____

Age: _____ Grade: _____ Sex: _____ Social Security #: _____

MA number or case number if MA is pending:_____

Address: _____

Home Phone: _____ Cell Phone: _____
Email: _____

Parent(s)/Guardian(s):_____

Education Decision-maker? _____ Medical Decision-maker? _____

Current Level of Support (Itinerant/Supplemental; Emotional Support/Learning Support, etc.)
_____

Primary/Secondary Disability Category(s): (*Cannot accept student unless Emotional Disturbance or Autism are listed or will be listed*)
_____

Referral Contact Information

Attending School: _____ School District: _____

LEA Name and contact information: _____

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Mental Health Information

Please Note: This information will help us to determine if the student meets criteria for an Outpatient or Partial Hospitalization Program classroom.

Reason for Referral (Please include information about physical/verbal aggression, property destruction, dangerous and disruptive behaviors in school, home and community):

Current/Previous Mental Health treatment the student has received or has been referred to (ex. outpatient, school based therapy, hospitalizations, acute partial, RTF etc)

If there is no current mental health treatment, what are the barriers to mental health treatment for this student and family?

Current Medications and compliance with medication:

Medical Conditions/Allergies:

Does the parent/guardian agree with this referral for mental health treatment? _____

Does the parent/guardian participate in IEP and other meetings at school? _____