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

Thank you for understanding that only a complete referral will be accepted and processed.

Please Note: Partial Hospital Treatment is funded through Medical Assistance.

Required Documents:

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

Child/Adolescent Referral Information

Name: _____ DOB: _____

Age: _____ Grade: _____ Sex: _____ MA number: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Parent(s)/Guardian(s):_____
Education Decision-maker (if not parent) : _____
Medical Decision-maker (if not parent): _____

Does the parent/guardian agree with this referral for mental health treatment? _____
Does the parent/guardian participate in IEP and other meetings at school? _____

Legal Involvement: ___Y ____ N CYF Involvement: ___Y ____ N
Current Level of Support (Itinerant/Supplemental; Emotional Support/Learning Support, etc.)
_____

Primary/Secondary Disability Category(s): (*Must be Emotional Disturbance or Autism)*

_____

Referral Contact Information

Current School: _____ Referring School District: _____

LEA Name and contact information: _____

Mental Health Information

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

Reason for Referral: (Check yes or no and explain all behaviors that are present)

Physical Aggression ____Y ____ N

Explain: _____

Verbal Aggression (including threats) ____Y ____ N

Explain: _____

Property Destruction ____Y ____ N

Explain: _____

Elopement from building/classroom ____Y ____ N

Explain: _____

Inappropriate sexual behaviors ____Y ____ N

Explain: _____

Disrobing and/or urination/defecation in inappropriate places ____Y ____ N

Explain: _____

Self-injurious behaviors or suicidal ideation/attempts ____Y ____ N

Explain: _____

Other unsafe or disruptive behaviors ____Y ____ N

Explain: _____

History of Suspensions: ____Y ____ N

Explain: _____

List current/previous mental health treatment the student has received or has been referred to (ex. SAP, 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?

_____

List Current Medications: _____

_____

Is the student compliant with medications (if applicable) ? ____Y ____ N

If no, please explain: _____

Medical Conditions/Allergies? ____Y ____ N

If yes, please explain: _____

I attest that the information provided is complete and accurate.

_____

Signature of Person completing this form