

**AMHERST H. WILDER FOUNDATION SOUTHEAST ASIAN SERVICES  
REFERRAL FORM FOR OUTPATIENT MENTAL HEALTH SERVICES  
YOUTH**

**451 Lexington Parkway North, Saint Paul, MN 55104**

**Phone: (651) 280-2310 Fax: (651) 280-3995 Attn: SEA Intake**

Wilder Foundation Administrative use only

Date referral received: \_\_\_\_\_ Referral Taken By: \_\_\_\_\_

Referral made to SEA staff \_\_\_\_\_  
Name Date

Self

Provider

Other

**REFERRED BY**

Date of Referral: \_\_\_\_\_

Name: \_\_\_\_\_ Role: \_\_\_\_\_

Provider: \_\_\_\_\_

Other Providers Involved: Name: \_\_\_\_\_ Role: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Name: \_\_\_\_\_ Role: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Name: \_\_\_\_\_ Role: \_\_\_\_\_ Contact #: \_\_\_\_\_

Does client currently see the following?

Primary Dr.  Y  N Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Contact #: \_\_\_\_\_

Therapist  Y  N Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Contact #: \_\_\_\_\_

Psychiatrist  Y  N Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Contact #: \_\_\_\_\_

Psychologist  Y  N Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Contact #: \_\_\_\_\_

Other  Y  N Name: \_\_\_\_\_ Place: \_\_\_\_\_ Contact #: \_\_\_\_\_

Has release been signed?  Y  N **If yes, please include release when mailing/faxing referral.**

**CLIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Alt. # \_\_\_\_\_

Parent Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(If different from above)

Legal Guardian (if not parent): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Primary Family Members: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# of Children or Siblings: \_\_\_\_\_ Ages: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_ Phone #: \_\_\_\_\_

SS# \_\_\_\_\_ Insurance Provider: \_\_\_\_\_ Member #: \_\_\_\_\_

English Ability of: Parent:  Fluent  Good  Limited  None

Child:  Fluent  Good  Limited  None

Previously Seen by Wilder:  Y  N If yes, Client #: \_\_\_\_\_

Transportation Issue:  Y  N : \_\_\_\_\_

Barriers to Treatment:  Y  N : \_\_\_\_\_

Medications: \_\_\_\_\_

**REASON FOR REFERRAL**

**Please indicate Yes or No for questions below, if yes, please describe.**

Is the client in immediate crisis?  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School Issues  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Mental Health Treatment  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Suicidal Ideation/ Attempts  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Depression  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Oppositional Behaviors  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sexuality Issues  Y  N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Inattention/Impulsive    Y   N    \_\_\_\_\_  
\_\_\_\_\_

Aggression                Y   N    \_\_\_\_\_  
\_\_\_\_\_

Anxiety                    Y   N    \_\_\_\_\_  
\_\_\_\_\_

Bizarre Thinking/  
Behaviors                Y   N    \_\_\_\_\_  
\_\_\_\_\_

Chemical Abuse           Y   N    \_\_\_\_\_  
\_\_\_\_\_

Recent/Past Trauma or  
Losses                    Y   N    \_\_\_\_\_  
\_\_\_\_\_

Specific presenting problem(s) (onset, duration, frequency, intensity; describe specifics) or other information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would referral source recommend for treatment options: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: Please let the client and parent(s)/guardian(s) know that you have made a referral to us and that we will be contacting them to schedule an appointment. Thank you.**

# **YOUTH PROGRAM**

## **INFORMATION TO REQUEST FROM THE REFERRAL SOURCES**

### **I. Schools (school counselor, school social worker, or TIP (Truancy Intervention Program))**

- Attendance report
- Grades
- Disciplinary report
- Special education assessments and IEP (Individual Education Plan)
- Any other relevant information like medication, other providers (probation, child protection, etc.)
- Release of information form

### **II. Hospitals:**

- Discharge summary and recommendations (Try to get this information before the client is discharged from the hospital, otherwise we need to get a release to medical records. It will take a long time.)
- Diagnostic assessments
- Medical history
- Medication Information (type of medication and dosage)
- School information
- Release of information form

### **III. Community Agencies/Providers:**

- School reports
- Diagnostic assessments
- Medical history (psychiatric reports, medication)
- Delinquent history (probation involvement)
- Other community providers who are working with client. Does the referral source have information about the community providers?
- Release of information form