

**INTERCEPT YOUTH SERVICES, INC.**

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**Intensive In-Home  
Referral Form**

Identifying Information			
Referral Date:			
Client:		Date of Birth:	SSN:
Phone:	Gender:	Race:	
Client Address:			Marital Status:
Parent/Guardian:		Work Phone:	
Current Address:			
School:	Grade:	Special Education: Yes/No	
Probation/Parole Officer:		DSS Case Worker:	
Primary Physician:		Other Professionals Involved:	
Psychiatrist:			
Medication:		Dosage:	

Medicaid Information	
Medicaid Recipient # (12 digit):	
Recipient Eligibility: Eligible Yes/No End Date:	
Service Availability: (weeks)	Date Verified:

Clinical Screening		
<input type="checkbox"/> Danger to Self/Others (explain below)	<input type="checkbox"/> Hospitalization Hx-#	<input type="checkbox"/> Legal Involvement
<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Outpatient TX	<input type="checkbox"/> Runaway Potential
<input type="checkbox"/> Sexually Inappropriate	<input type="checkbox"/> Suicide Attempts-#	<input type="checkbox"/> Chronic Medical Problems - Child
<input type="checkbox"/> Peer Relationship Problems	<input type="checkbox"/> Child Substance Abuse	<input type="checkbox"/> Victim Physical/Emotional Abuse
<input type="checkbox"/> Parent-Child Problems/ Defiance	<input type="checkbox"/> Eating/Sleeping Disturbance	<input type="checkbox"/> Victim Sexual Abuse/Molest
<input type="checkbox"/> School Failure/Behavior Problems	<input type="checkbox"/> Anxiety/Phobias	<input type="checkbox"/> Death/Loss Issues
<input type="checkbox"/> Truancy/Drop Out/Expulsion	<input type="checkbox"/> Sadness/Depression	<input type="checkbox"/> Foster Placement
Reason for Referral:		

If available, please provide:			
<input type="checkbox"/> Social History	<input type="checkbox"/> Current Psychological	<input type="checkbox"/> Legal History	<input type="checkbox"/> Current Physical Exam

Prescreen Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Supervisor/Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Approved ( ) Denied ( )