IMPACT PROGRAM REFERRAL FORM

Priority Score_____
Date Received _____

****MUST HAVE THE INVOLVEMENT OF TWO COMMUNITY AGENCIES TO BE REFERRED****

Child's Information

Child's Name: _____ ID# _____

Date of Birth: _____ Social Security Number: _____ Sex: _____

Family/Parental Information

Parent/Guardian Name: _____ Relationship: _____

Address: _____

County of Residence: _____ Phone: _____

Mental Health

☐ Yes / No ☐ Has the child ever received and/or is currently receiving services from a Mental Health Provider?
If other than the Pennyroyal Center, specify provider: _____

☐ Yes / No ☐ Has the child been diagnosed with Autism Spectrum Disorder? *

Hospitalizations

☐ Yes / No ☐ Has the child been hospitalized in the last three months?

☐ Yes / No ☐ Has the child been in residential treatment in the last six months?

Agency Involvement *Indicate all agencies involved with the child and list the agency contact person.*

☐ Yes / No ☐	Department of Community Based Services	Worker: _____
☐ Yes / No ☐	Court Designated Worker	Worker: _____
☐ Yes / No ☐	Department of Juvenile Justice	Worker: _____
☐ Yes / No ☐	Pennyroyal Center Crisis Services *	Contact: _____
☐ Yes / No ☐	Pennyroyal Center Outpatient/School-Based Therapy	Clinician: _____
☐ Yes / No ☐	Other (specify) _____	Contact: _____

School: _____ Grade: _____

☐ Yes / No ☐ Special Education and Individual Education Plan

Behavioral Descriptors *Indicate each present behavior by checking all behavior(s) that apply.*

_____ Verbally aggressive
_____ Physically aggressive with peers and/or adults
_____ Destruction of property
_____ Defiant behavior
_____ Explosive behavior
_____ Fascination with matches/lighters/fires
_____ Difficulty with peer interaction
_____ Verbalizes self-harm and/or deliberately harms and/or attempted suicide
_____ Trauma
_____ Anxiety/worry
_____ Depression
_____ Socially withdrawn
_____ Dangerous impulsivity
_____ Inappropriate sexual behavior
_____ Runs away from home and/or school
_____ Other: (specify) _____

Further information or circumstances that led to this referral: _____

_____

_____

Physical Health/Disabilities

☐ Yes / No ☐ Does the child have a diagnosed or suspected physical health problem?
If yes, specify: _____

Intellectual Developmental Disability (I/DD)

☐ Yes / No ☐ Has the child been diagnosed with an Intellectual Developmental Disability (I/DD) diagnosis?
If yes, specify: _____

History of Substance Use

☐ Yes / No ☐ Does the child have a history of substance use?

Referral Source: _____

Agency/Organization: _____

Phone Number: _____ Date completed: _____

Please email referral to: impact@pennyroyalcenter.org.

For further information, please contact Serena Eldridge at (270) 365-2008.

COMPLETED BY IMPACT PERSONNEL ONLY

Mental Health	_____	
Hospitalizations	_____	
Agency Involvement	_____	(additional point for DCBS _____ / CDW _____/ DJJ _____ / Crisis _____)
Behavioral Descriptors	_____	(point for each behavior)
Physical Disabilities	_____	
I/DD	_____	
Substance Use	_____	
Priority Score Total	_____	