MERCY BEHAVIORAL HEALTH

CHILD AND ADOLESCENT DAS REFERRAL FORM

Phone (412) 323-4598 & 412-697 3418 (after 6pm) and Fax (412) 320-2398

NAME		**DATE OF REFERRAL**	
AGE & DATE OF BIRTH		**MA/CCBHO#**	
SOCIAL SECURITY #		**SCU/COUNTY #**	
PHONE NUMBER		**OTHER INSURANCE/POLICY #**	
PARENT/GUARDIAN		**ADDRESS**	

REFERRAL SOURCE/RELATIONSHIP	**AGENCY**	**PHONE NUMBER**

PRESENTING NEEDS/REASON FOR REFERRAL:

DIAGNOSIS (IF ASD IS DX- IT MUST BE LEVEL 1. LEVEL 2 & 3 ARE NOT ACCEPTED INTO THE DAS PROGRAM)
DSM 5 DIAGNOSIS:
MEDICAL DIAGNOSIS:
CURRENT MEDICATIONS – PLEASE INCLUDE THE STRENGTH, DOSAGE AND TIME ADMINISTERED
1.
2.
3.
4.
5.

SPECIAL NEEDS: MEDICAL ISSUES/ALLERGIES/SPECIAL FOOD NEEDS

PLAN FOR DISCHARGE: (Disposition must be clear and all consumers must have a place to go upon D/C. If consumer does not have a case manager, a referral for case management services should be made prior to them entering DAS)

PARENT/GUARDIAN OR REFERRAL SOURCE NEEDS TO PROVIDE THE FOLLOWING IN ADDITION TO REFERRAL
1. MOST RECENT PHYSICAL EXAMINATION (WITHIN 1 YEAR- IF NOT PARENTS NEED TO OBTAIN NEW PHYSICAL) 2. PROOF OF IMMUNIZATIONS 3. SICKLE CELL SCREENING RESULTS (IF AFRICAN AMERICAN) 4. INSURANCE CARD 5. PSYCHIATRIC EVALUATION (IF REQUESTED)

SCHOOL	GRADE	REG ED/SPEC ED	DISTRICT

CURRENT SERVICES		
TYPE OF SERVICE	**NAME/AGENCY**	**NUMBER**
PSYCHIATRIST		
THERAPIST (SPECIFY TYPE- OP, FBMH, BHRS, SBT)		
CASE MANAGER		
CYF/OTHER:		
PCP (AND DATE OF LAST PHYISCAL EXAM)		