FAX this form anytime (secure, confidential 24/7) to: **610-383-1285**

FROM: | My Phone: | My Fax:

Relationship to child being referred: | Date:

Child's Name: | Social Security Number:

Date of Birth: | Age: | Gender: | Pediatrician:

Mother: | Work: | Home:

Father: | Work: | Home:

Child's mailing address:

Legal Custody: | Phone:

Ethnicity: | Religion: | Primary Language:

Primary health insurance and ID number:

PA MA ID #: | Office Use (EVS Date):

Reason for referral:

Please check all that apply

Violence against adults ☐ Violence against peers ☐ Places self in danger ☐

DHS client ☐ Suicide attempt ☐ Mental Retardation ☐ School problems ☐ Drug abuse ☐

Alcohol abuse ☐ Autism or PDD ☐ Delinquency ☐ Currently in a hospital or Residential Treatment ☐

Current Medication & dosages and/or other health concerns:

What **phone number** should we call, and **when** should we call you?