BERKSHIRE FARM CENTER AND SERVICES FOR YOUTH

POWER PROJECT

EMPOWERING CHILDREN AND FAMILIES

4419 3RD AVE. BRONX NEW YORK 10457
(718) 220-4247/(646) 942-7743 FAX (718) 220-4248
PHONE/SELF-REFERRALS: (646) 942-7743
EMAIL REFERRALS: JGILMORE@BERKSHIREFARM.ORG

REFERRAL FORM

REFERRAL PACKET

- THE REFERRAL FORM **(**Applicable info only**)**
- HOSPITAL/MH PROVIDER= DISCHARGE/PSYCHOSOCIAL INFORMATION
- SCHOOL/CBO - PSYCHOSOCIAL ASSESSMENT **OR** COPY OF IEP WITH MENTAL HEALTH DIAGNOSIS**

**A PARENT/GUARDIAN MAY BRING THE SUPPORTING DOCUMENTS TO THE INTAKE

REFERRAL SOURCE INFORMATION

AGENCY _____ CONTACT _____

ADDRESS _____ TELEPHONE # _____

DSM 5 DIAGNOSIS: _____

REASON FOR REFERRAL/PRESENTING ISSUES_____

CLIENT INFORMATION

CLIENTS NAME_____ AGE _____ D.O.B _____

MEDICAID #_____SS#_____

ADDRESS_____APT# _____ ZIP_____

TELEPHONE # ( ) _____ LANGUAGE: ENGLISH _____SPANISH_____ OTHER _____

PARENT NAME _____LEGAL GUARDIAN_____

ADDRESS_____ADDRESS_____

TELEPHONE # ( ) _____ LANGUAGE: ENGLISH _____SPANISH_____ OTHER _____

SCHOOL/VOCATIONAL

SCHOOL NAME_____ ADDRESS_____

TELEPHONE #:_____REGULAR ED:_____ IEP:_____ GRADE/CREDITS _____

SCHOOL CONTACT NAME _____ TELEPHONE #_____ TITLE:_____

EMAIL_____

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SUBSTANCE ABUSE HISTORY

CHECK ALL THAT APPLY:

_____cigarettes/Vape _____alcohol _____marijuana _____cocaine/crack _____ ecstasy

_____PCP/dust _____heroin _____LSD/Acid _____K2 _____Other

CLIENT HISTORY/SERVICES RECEIVED:

INPATIENT (PSYCHIATRIC) **FROM**_____ **TO** _____

HOSPITAL_____ CONTACT NAME_____

ADDRESS_____TELEPHONE#_____

ACS/JJ INVOLVEMENT HISTORY; CHECK ALL THAT APPLY WITH DATES OF ADMISSION & DISCHARGE

RESIDENTIAL_____ _____ **FOSTER CARE**_____

GROUP HOME _____ **DETENTION**_____ **PREVENTION**_____

CURRENT AGENCY (IF APPLICABLE)_____

CONTACT NAME_____

ADDRESS_____TELEPHONE#_____

EMAIL_____

OUTPATIENT MENTAL HEALTH; FROM _____**TO** _____

AGENCY_____ CONTACT NAME_____

ADDRESS_____TELEPHONE#_____

MEDICATIONS? YES ____NO_____ CURRENT MEDICATIONS_____

IS CLIENT COMPLIANT W/MEDS? _____