FS-010P
Sunrise Children's Services
Provider Referral Form

Location:________________________
Phone:__________________________
Fax:____________________________

Service Requested:

Targeted Case Management **Therapy** **Psychiatry**

Child's Name:______________________________________ Referral Date:______________________________
Sex: ☐ Male ☐ Female Date of Birth:____
SSN:____

Custody of: ☐ Parent ☐ DCBS ☐ DJJ ☐ Other:____
Name:____
Address: ____ Phone:____________________________

School:____ Grade:____________________________

Referred by (Agency/Contact Person)____
Phone:____

Checklist for Eligibility

Check One	Criteria
☐ Yes ☐ No ☐ Not Sure	Does the child have a medical card? Med #:______________________
☐ Yes ☐ No ☐ Not Sure	Does the child have a mental health diagnosis? If so what is the diagnosis? ______________________
☐ Yes ☐ No ☐ Not Sure	Has the child been having difficulties in the home, school, or community for at least the last 6 months?

Reason for Referral (Check all that apply)

School	Home	Community
☐ Frequent disciplinary referrals	☐ Requires frequent discipline	☐ History of vandalism
☐ Sporadic disciplinary referrals	☐ Defies adults requests	☐ History of theft
☐ History of suspensions	☐ Noncompliant with chores	☐ Physically aggressive
☐ Physically aggressive	☐ Physically Aggressive	☐ Sexually promiscuous
☐ Destructive of property	☐ Destructive to property	☐ History of substance abuse
☐ Truancy	☐ Theft	☐ Sexually abusive
☐ Theft	☐ Dishonesty	☐ Involvement with cult or gang
☐ Dishonesty	☐ Hyperactivity	☐ Fire setting behaviors
☐ Defiant Behavior	☐ Impulsivity	☐ Seeks negative peers
☐ Hyperactivity	☐ Attention Problems	☐ Runs away
☐ Impulsivity	☐ Unusual fears or anxiety	☐ Other legal problems
☐ Attention Problems	☐ Social withdrawal or isolation	
☐ Unusual fears or anxiety	☐ Sadness/depression	**Other Concerns**
☐ Difficulty with peer relations	☐ Poor self-care/hygiene	______________________
☐ Social withdrawal or isolation	☐ Irritability	______________________
☐ Sadness/Depression	☐ Mood swings	______________________
☐ Poor self-care/hygiene	☐ Appetite Problems	______________________
☐ Irritability	☐ Sleeping difficulties	______________________
☐ Mood swings	☐ Difficulty with sibling relations	______________________
☐ Appetite problems		______________________
☐ Learning difficulties		______________________
☐ Poor grades		

Other difficulties: ____
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______________________________________ ______________________
Staff Signature and Credentials Date