

# INTERVENTION SERVICES, INC. REFERRAL FORM

Urgent (3 days)  Routine (7 days)

**Fax to:** General number: 407-331-8659 **OR E-mail to:** [referrals@isifl.org](mailto:referrals@isifl.org)  
**OR Mail to:** INTERVENTION SERVICES, INC.; 150 Spartan Dr.; Maitland, FL 32751

## DEMOGRAPHIC INFORMATION:

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Parents/Caregivers Names: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
 Parent/Guardian home  Relative home, placed by DCF  Regular foster home  Therapeutic foster home  Specialized foster hm  
Address: \_\_\_\_\_ County: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Special Ed. Placement? NO YES (Circle: EBD / SLD / EMH / TMH / VE)  
Client's preferred language: \_\_\_\_\_ Caregiver's preferred language: \_\_\_\_\_ Bilingual required? YES NO

## DEPENDENCY/DELINQUENCY INVOLVEMENT: Parental rights terminated? Yes No\*

No PS/FC/DJJ involvement  Dependent (foster care) status\*  Protective Services status  Dept. Juvenile Justice involved  
Case Manager: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*Required for Dependent children not TPR'ed: Biological Parent/Legal Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## CASE COORDINATION INFORMATION:

Person completing form: \_\_\_\_\_ Referring Agency: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_ Date: \_\_\_\_\_  
Client is currently receiving:  In-home /  In-school /  Individual Therapy /  Medication /  Other: \_\_\_\_\_  
Therapist Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

## FUNDING INFORMATION

Funding: Medicaid #: \_\_\_\_\_ Harmony / Amerigroup / United / FHP (PMHP) / Magellan / AHCA  
Non Medicaid cases: Funding (please circle) FSPT-HSA; FSPT-CHS; CMS; Private Insurance; Americhoice; Evercare; SAMH (ADM)  
Authorization Number: \_\_\_\_\_ Auth period: \_\_\_\_\_

## PROBLEM DESCRIPTION – This section must be completed in order for referral to be processed.

SERVICES REQUESTED:  Behavior Analysis  Counseling  Psychiatric

Yes No

- Has physical aggression or property damage resulted in injury in past 6 months? *Describe severity:*  
  Are other people's safety at risk due to client's violence? *Describe:*  
  Has client been arrested or do you feel that is in risk of getting arrested?  
  Has client been suspended from school in past month?  
  Any serious suicidal gestures/attempts in past 6 months? *Describe:*  
  Has client been admitted to crisis units? *When? \_\_\_\_\_; Specify: \_\_\_\_\_*  
  History of being abused: Specify: \_\_\_\_\_

### Please describe symptoms to be treated:

Physical Aggression	Runaway	Tantrums	Lying	Depressed Affect
Verbal Aggression	Property Destruction	Truancy	Sexually Acting Out	Anxious Affect
Non-Compliance	Disruptive Behavior	Stealing	Self-Injury/Suicidal	Other: _____

History of treatment (year) \_\_\_\_\_; Previous diagnosis \_\_\_\_\_ Developmental problem: \_\_\_\_\_

## FOR INTERVENTION SERVICES USE ONLY:

Hx of treatment at ISI: \_\_\_\_\_; Previous counselor: \_\_\_\_\_

Other information: \_\_\_\_\_

CBA Assigned: \_\_\_\_\_ Counselor Assigned: \_\_\_\_\_ Date Assigned: \_\_\_\_\_ LE: \_\_\_\_\_