Lead4Life
www.Lead4lifeinc.org

IFPS/Wrap-Around Referral Form

240-499-8949 (Telephone) PMI@lead4lifeinc.org (Email)

~Please complete the entire form~

Date of Referral: _____ Referred By (Name/Title/Agency): _____

Phone: _____ Email: _____

Relationship to Family/Child: _____

IFPS/Wrap-Around Agency: _____

IFPS/Wrap-Around Worker Name: _____

Phone: _____ Email: _____

CHILD(REN) INFORMATION

Child's Name (First/Last): _____ D.O.B./Age: _____

Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Child's Name (First/Last): _____ D.O.B./Age: _____

Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Child's Name (First/Last): _____ D.O.B./Age: _____

Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____

(Street) (Apt #) (City) (State & Zip Code)

Medicaid ☐ / #:_____ Private Insurance ☐/Info: _____

_____

_____

FAMILY INFORMATION-All Caregivers

Name: (First/Last): _____ D.O.B./Age: _____

Relationship to Child: _____

Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____

(Street) (Apt #) (City) (State & Zip Code)

Phone: _____ E-mail: _____

Name: (First/Last): _____ D.O.B./Age: _____

Relationship to Child: _____

Gender: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____

(Street) (Apt #) (City) (State & Zip Code)

Phone: _____ E-mail: _____

CHILD'S NEEDS

It is helpful for us to have as much information on the child you are referring so we can assign him/her to a service/mentor who can best serve their needs. Please provide as much information as possible in this section.

Has the child had a previous psychological evaluation? ☐YES ☐NO If so, completed: _____
Has the child been hospitalized in the past 6 months? ☐YES ☐NO If so, where and duration of stay: _____
Has the child been detained in the past 6 months? ☐YES ☐NO If so, what was the reason: _____
Has the child been removed from the home for any reason? ☐YES ☐NO If so, what was the reason: _____
Does the child have any other special communication needs? ☐YES ☐NO If so, please explain: _____

What are the current symptoms promoting the request for service and/or mentor (check all that apply)?

☐ Anxiety
☐ Depression
☐ Withdrawn/Poor Social Interaction
☐ Mood Instability
☐ Psychosis or Hallucinations
☐ Bizarre Behavior
☐ Unprovoked Agitation or Aggression
☐ Self-Injurious Behaviors
☐ Eating Disorder Symptoms
☐ Poor Academic Performance
☐ Behavior Problems at Home
☐ Behavior Problems at School
☐ Inattention
☐ Hyperactivity
☐ Sexual Behavior Issues
☐ MR Diagnosis
☐ Possible Developmental Delays
☐ Possible Autism
☐ Lack of Parent Involvement
☐ Other: _____
_____

FAMILY'S NEEDS

Please feel free to provide us with any additional information not included in your documents provided to Lead4Life you think may be helpful to us in providing services to this family:

_____

_____

_RECOMMENDED SERVICE'S

☐ Clinical Mentoring ~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
☐ Social Mentoring ~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
☐ Parent Mentoring ~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
☐ Individual Therapy~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
☐ Family Therapy~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
☐ RISE~ Duration of service requested: _____ (Hours per month) for _____ (Number of months)
Comments:_____
_____

L4L INTERNAL USE ONLY

Reviewed by: _____Date: _____

Assigned to: _____/_____/_____ Date: _____

Comments: _____

_____

Confirmation of Services to (mentor/billing/referral source): _____ Date: _____

☐ Phone call ☐ Email ☐ Text

We appreciate you taking the time to complete this referral form and for giving us the opportunity to serve the family. Please feel free to call/e-mail us with any questions or concerns.