



RTC REFERRAL FORM

To make a referral to the RESIDENTIAL TREATMENT CENTER at HALLMARK YOUTHCARE, fill out the information requested below and fax to **804-784-5261** or mail the necessary documentation. Once we receive the required information, the intake coordinator will call to confirm receipt of the packet. The Clinical Team will review the packet and within one business day will advise you of our recommendation for treatment. For any questions, please feel free to call the Intake Department @ **804-784-6432**.

NAME OF CLIENT: _____

GENDER: _____ DATE OF BIRTH: _____ SS#: _____

LEGAL GUARDIAN: _____ PHONE: _____

PARENTAL INVOLVEMENT: Yes No PARENTAL RIGHTS TERMINATED: Yes No

REFERRING AGENCY: _____

INSURANCE: _____ BACKUP FUNDING SOURCE: _____

CURRENT PLACEMENT: _____

REASON FOR DISCHARGE: _____

CURRENT MEDICATIONS: _____

IEP: Yes No GRADE: _____ IQ: _____ TEST DATE: _____

PLEASE INCLUDE AS MUCH AS POSSIBLE OF THE FOLLOWING INFORMATION:

- Most recent psychological evaluation (if available)
- Discharge summaries for all placements within past 6 months - 1 year (if available)
- Most recent psychiatric evaluation (if available)
- Social history (if available)
- Information describing behavior within past 2 months (examples: treatment plan, nursing/progress notes, letter from parent, therapist, etc.)

List of placements/out-patient therapy attempts for the past two years:

| <i>Placement</i> | <i>Dates</i> | <i>Reason for leaving</i> |
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Legal charges:

| <i>Charge</i> | <i>Date</i> | <i>Disposition</i> |
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