



Allegheny Children's Initiative

A member of the Partners For Quality family of agencies.

2304 Jane Street
Pittsburgh, PA 15203
Phone: 412-431-8006
Fax: 412-431-8124

BEST PRACTICE EVALUATION REFERRAL FORM

Referral Source (if other than parent):	Contact Person:	Phone:
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Child's Name:

Date of Birth / Age:	Birth Gender:	Race:
	Identified Gender (if different):	Ethnicity (Hispanic, Latino, or Spanish origin?):

Address:	Phone:
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Social Security Number:	Insurance:	Medical Assistance Number:
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Legal Guardian (1):	Relationship:	Address (if different from above):	Phone (if different from above):
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Legal Guardian (2):	Relationship:	Address (if different from above):	Phone (if different from above):
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Chief Complaint: (current symptoms, when did the symptoms begin, how severe are the symptoms):
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Current Strengths (skills, abilities, likes, extracurriculars, etc.):

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School:	Grade Level:
	IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there current school concerns? If so, please describe:

Past and Current Mental Health Treatment		Provider Name/Additional Comments
<input type="checkbox"/> Service Coordination	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Outpatient (office or school-based)	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> BHRS / Wraparound	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Family Based	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Psychiatric Hospitalization	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Residential Treatment Facility	<input type="checkbox"/> Past <input type="checkbox"/> Current	
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Past <input type="checkbox"/> Current	

Has a previous psychiatric or psychological evaluation been completed:

Yes, Date: _____ Provider Name: _____ No

Current Legal Involvement	Contact Person	Phone
<input type="checkbox"/> CYF		
<input type="checkbox"/> Juvenile Probation		
<input type="checkbox"/> Custody		
<input type="checkbox"/> Other (please specify)		

For inquires or questions:
 Intake Services Coordinator
 Phone: 412-390-3849
 Fax: 412-431-8124
 E-mail: aci-intake@pfq.org