Tennyson Center *for* Children
CHANGING LIVES. GIVING HOPE.

Client Name: _____

Client DOB: _____

REFERRAL FORM

Please complete this form in its entirety and send it to Tennyson Center's (TCC) admissions department at admissions@tennysoncenter.org or fax to 303-433-9702. Please send any additional documentation that can help determine if the client is an appropriate fit for our program, such as assessments, evaluations, progress notes, discharge summaries, Individualized Education Plan, and Family Service Plan if DHS. Once the information is reviewed, TCC's admissions team will outreach the legal guardian/referral source to discuss services. If, for any reason, the client is not appropriate for our program, the referral source will be notified.

Referral Source Contact Information	
Referring for : ☐ Community-Based Services (in-home) ☐ School support only ☐ Day Treatment ☐ Residential (RCCF) ☐ SSU (short-term residential) ☐ BRANCH	
Funder for Services:	
Referring Agency:	
Contact Person:	Referral Date:
Address:	
Phone Number:	Email:
Best time to contact referral source if more information is needed:	

Client Information	
Client name:	Date of Birth:
Gender:	Primary Language:
Client Address:	Client Phone Number:
Primary Insurance Provider:	Policy Number:
Secondary Insurance Provider:	Policy Number:

Legal/Education Information	
Legal Guardian(s):	Phone number:
Relationship to client:	Does child reside with someone who is not their legal guardian? ☐ Yes ☐ No
Guardian(s) Address (if different than above):	
Please provide names/contact information for the individual(s) who holds the following rights/custody:	
Physical Custody:	Phone number:
Medical Rights:	Phone number:
Therapeutic Privilege:	Phone number:
Educational Rights:	Phone number:
Most recent school/district:	
Does client have an IEP: ☐ Yes ☐ No	Current grade:
Is the client on probation? ☐ Yes ☐ No	Previous Charges: Pending Charges:
Probation Officer:	Phone Number:
GAL:	Phone Number:

Health Information	
Mental Health Diagnoses:	
Medical Conditions (ex. asthma, allergies, diabetes, seizures, dietary needs):	
Psychiatric Medications:	Prescriber: Address: Phone:
All Other Medications (ex. inhaler, ointments):	Prescriber: Address: Phone:

Family/Trauma Information
Family members involved in treatment:
Siblings (name, age, do they reside with client):
Extent of involvement (ex. contact frequency, visitation requirements, treatment expectations):
Has the client experienced any trauma (ex. abuse, neglect, removal from home, inconsistent caregivers, traumatic incidents):

Behavior/Symptom Information		
Client Strengths/Interests:		Coping skills/helpful interventions:
Triggers:		Cultural Considerations:
Safety concerns for staff going into the home (ex. aggression towards staff, gang involvement, aggressive pets):		
Behavior Concerns:	**Yes or No:**	**Details (severity, frequency, etc.)**
Emotion Regulation		
Depression		
Anxiety		
Mood Swings		
Attention Span/Focus		
Following Directions		
Verbal Aggression		
Physical Aggression		

Property Damage		
Homicidal Ideation		
Suicidal Ideation		
Self-Harm		
Sexualized Behaviors		
Elopement/Running		
Peer Relationships		
Attachment Concerns		
Substance/Alcohol Use		
Gang Involvement		
Stealing		
Fire Setting		
Animal Cruelty		
School Truancy		
Psychosis/Hallucinations		
Sleep Disturbances		
Hygiene		
Enuresis/Encopresis		
IQ/Cognitive Functioning		
Developmental Delay		
Please explain why services are being requested:		

Placement and Mental Health Treatment Information (Required for Residential and Day Treatment Referrals)			
Reason for placement:		Current provider name and location:	
Requested services start date:		Goal for placement:	
Permanency goal:		Anticipated length of stay:	
Placement History (including hospitalizations, inpatient, kinship, group, foster, RCCF, detention, etc.)			
Name/Location	Type of Placement	Dates of Placement	Reason for Change
Mental Health Treatment History (including outpatient, in-home, psychiatry, ABA, substance use, etc.)			
Name/Location	Type of Treatment/Frequency	Dates of Treatment	Reason for Services Ending