

Client Name:	
Client Date of Birth: _	

REFERRAL FORM

Thank you for your interest in Tennyson's programs and services. Please complete this form and email it to Tennyson at admissions@tennysoncenter.org. We would appreciate it if you could also send any additional documentation that can help us determine if and how we can best support the person or family. Examples of documentation that could be helpful include assessments, evaluations, discharge summaries, Individualized Education Plans (IEP), and/or Family Service Plan (a copy of the student's IEP is required for all day treatment referrals). We will be in communication regarding the referral within one business day.

Referral Source Contact Information		
Referring for: ☐ Day Treatment ☐ ASPEN Day Trea	tment ☐ Community-Based Services ☐ BRANCH	
☐ Child First ☐ Outpatient Services ☐ Prevention ☐ PCIT		
Funder for Services:		
Referring Agency:		
Contact Name:		
Phone Number:	Email:	
Is the client/family aware that a referral has been made to TCC? Yes No		
How did you hear about Tennyson Center? ☐ Cur	rent/Former Tennyson Client	
☐ County Department of Human Services ☐ Hosp	oital Insurance Previous experience with Tennyson	
☐ School District ☐ Social media ☐ Tennyson	Community Outreach Manager	
☐ Tennyson Employee name	🗆 Other	
Client Information		
Name:	Gender Identity:	
	☐ Female ☐ Male ☐ Transgender Female	
	☐ Transgender male ☐ Nonbinary ☐ Other Preferred Pronouns:	
	□ She/her □ □ He/his □ □ They/Them	
Address	□ Sile/fiel □ □ He/fils □ Tiley/ filefil	
Address:	Client Phone Number:	
	Client Email:	
Legal Guardian(s) (if applicable):	Relationship to Client:	
Guardian's Address (if different from above):	Phone number:	
	Email address:	
Primary Language spoken in home:		
Therapeutic privilege (LAN) holder (if applicable):	Phone number:	
	Email:	
Caseworker name (if applicable):	Phone number:	
	Email:	

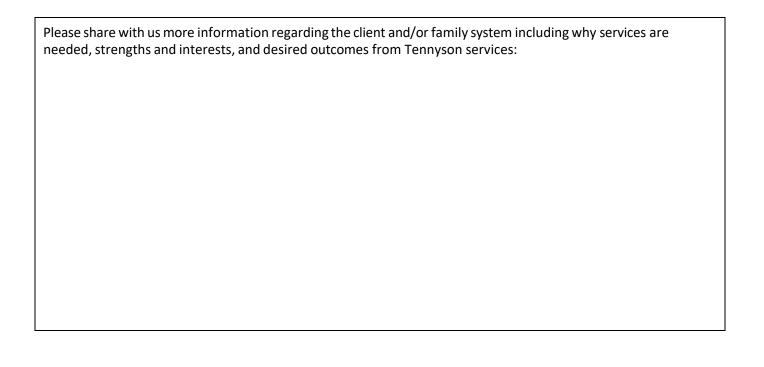
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	Email:	
IEP?: □Yes □No	Current school:	
Current grade:		
Primary Insurance Provider:	Policy Number:	
Secondary Insurance Provider:	Policy Number:	
Health Information Mental Health Diagnoses (if applicable):		
Medical Conditions (for example, asthma, allergies, dia	abetes, seizures, dietary needs, etc.):	
Is the individual currently on any medications? (If so, please list name of medication, dose, dosing times, and		
prescribing physician)		
☐ Yes ☐No ☐ Unknown		
Family Information Has the individual experienced any trauma (for example, abuse, neglect, removal from home, inconsistent		
caregivers, traumatic incidents, etc.):	ole, abuse, neglect, removal from nome, inconsistent	
Cultural Considerations:		
	mple aggression towards staff, gang involvement.	
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Behavior/Symptom Information		
Behavior Concerns	Y/N	Details (severity, frequency, etc.)
Depression		
Anxiety		
Verbal Aggression		
Physical Aggression		
Property Damage		
Homicidal Ideation		
Suicidal Ideation		
Self-Harm		
Sexualized Behaviors		
Elopement/Running		
Substance/Alcohol Use		
Gang Involvement		
Fire Setting		
Animal Cruelty		
School Truancy		
Psychosis/Hallucinations		
Cognitive Functioning		
Developmental Delays		
Enuresis/Encopresis		
Hygiene		

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Thank you again for your referral and we will be in communication in one business day!

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