CHECKLIST FOR MENTAL HEALTH – CHILD/ADOLESCENT REFERRAL

For emergency (crisis) call (541) 474-5360

Attn: CRT Intake Coordinator ▪ Children's Resource Team ▪ Options for Southern Oregon, Inc. ▪ Mental Health
1181 SW Ramsey Ave ▪ Grants Pass, OR 97526
Phone: (541) 244-3103 ▪ Fax: (541) 479-2450

Date of Referral: _____ MH Client Case No: _____

Name:_____SSN _____ DOB:_____
(First) (MI) (Last)

Address: _____Phone:_____ Age_____ F___ M___
(Street) (City) (Zip Code)

Parent/Guardian Name: _____School _____

Referring Person/Agency (If other than parent) _____Contact No:_____

Primary Care Physician: _____ Parent aware of referral? Yes __ No __

Instructions: ***Circle*** all behaviors that apply to this child. Please refer a child for a mental health evaluation when indicated.

1. FEELINGS
a. restless
b. sad
c. guilty
d. euphoric
e. irritable
f. feels out of control
g. sullen
h. fearful
i. lonely
j. cries excessively
k. cries too little
l. anxious
m. angry
n. self critical

2. BEHAVIOR
a. impulsive
b. fire setter
c. problems in school
d. threatens/harms others
e. overactive
f. suicidal
g. sexually acts out
h. sexually offends
i. sexually preoccupied
j. steals
k. tortures animals
l. self-destructive
m. lies
n. substance abuse
o. destroys property
p. refuses to talk
q. compulsive
r. listless

3. SOCIAL INTERACTIONS
a. withdrawal
b. clings excessively
c. difficulty making/keeping friends
d. failure to respond socially (infants)
e. aggressive
f. defiant
g. argues excessively
h. inattentive
i. acts young
j. victimized
k. disobedient: possible legal violations

4. THINKING
a. frequently confused
b. daydreams excessively
c. out of touch with reality
d. distracted
e. bizarre ideation
f. mistrustful
g. obsessive
h. delusional
i. blames others
j. frequent memory loss
k. problems concentrating
l. suicidal ideation

5. PHYSICAL PROBLEMS
a. wets bed
b. wets during day
c. soils pants
d. frequent stomach aches
e. weight loss/gain
f. vomits or uses laxatives
g. problems eating
(poor appetite, nausea, eats non-foods)
h. frequent headaches
i. lacks energy
j. problems sleeping
(nightmares, sleep-walking)

Reason for Referral:_____

_____

_____

_____

Former Therapist:_____ Therapist Request: _____

FOR OFFICE USE ONLY

Insurance Information:

OHP Recipient ID No:_____Effective Date:_____ Perc Code:____

[ ] SEXUAL ABUSE REFERRAL Assigned Therapist: _____

Revised: October 2013