



Outpatient Youth Therapy Referral Form

Child's Name: _____

Preferred Name: _____ **Date of Birth:** _____ **Age:** _____

We care about understanding who you are. If you don't see yourself reflected in the categories provided below, please use the text boxes to write in your answer.

Sex assigned at birth: Male Female Intersex

Gender Identity: Male Female Non-binary / Gender Nonconforming
 Questioning / Not sure Prefer not to say
 Not listed. Please describe: _____

Ethnicity: Hispanic or Latino/a non-Hispanic or Latino/a

Race: (if multiracial please check all that apply)

- American Indian or Alaska Native White / Caucasian
- Asian Native Hawaiian / Pacific Islander
- Black or African American Prefer not to say
- Another Race Not Listed. Please describe: _____

Primary language(s) spoken in the home:

- English Other Language(s). Please describe: _____

Primary Caregiver(s) Information

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Additional Caregiver(s) Information

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Contact Information of Referring Person

Referring Person: _____

Agency: _____

Phone Number: _____

Email Address: _____

Reason for Referral: Please include the following information: any traumatic experiences or exposures, concerns regarding the child’s mental health, ability to learn, developmental concerns, or any other information that you feel is helpful to share.

What are the current custody arrangements for the child?

- Full custody Joint legal, full physical custody Joint legal and physical custody
- Foster care Guardianship Kinship care
- Other – please explain: _____

Are there any plans to request change in the custody arrangements?

- Yes No

If yes, please explain: _____

Medical Information

Does the child have a Primary Care Provider? Yes No

Provider's Name: _____

Provider's Practice: _____

Provider's Phone Number: _____

Are there any medical concerns or diagnoses for the child? Yes No

If yes, please explain: _____

Is the child currently taking any medications? Yes No

If yes, please list the medications and the dosages:

Medication Name	Dosage

Insurance Information

Insurance Name/Company: _____

Member ID #: _____

Group #: _____

Subscriber Name and Date of Birth: _____

Relationship to Child: _____

Claim information phone number on the back of card: _____

Additional Information

What school does the child attend? _____

Does the child have an IEP or 504 plan? Yes No

Has the child previously or do they currently receive additional services (Early On, Special Education, Speech and Language Services, Occupational Therapy, etc.)? Yes No

If yes, please list services and providers of the child: _____

Has this child previously worked with a mental health therapist? Yes No

Are there other children in the home? Yes No

If yes, please complete the following section:

Other Children's Names	Age	Gender	Relationship to Client

Is there any additional information that you would like the Resiliency Center to know?

To learn more about additional services offered by the WMU Resiliency Center please contact our main office at 269-387-7073 or visit our website at wmich.edu/unifiedclinics/resiliencycenter.

Please complete the attached Trauma Symptom Checklist (Henry, Black-Pond & Richardson, 2010) by marking known or suspected trauma exposure, as well as other concerns the child may present with. For children 0-5 years old, please complete the section starting on page 5. For children 6 and up, please complete the section starting on page 6:

Children 0-5:

Known or Suspected Trauma Exposure:		
	Physical abuse	Exposure to drug activity (aside from parental use)
	Neglectful home environment	Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
	Emotional abuse	Lengthy or multiple separations from parent
	Exposure to domestic violence	Placement outside of the home (kinship care, foster care, residential)
	Exposure to other chronic violence	Loss of significant people, places, etc.
	Sexual abuse or exposure	Frequent/multiple moves; homelessness
	Parental substance abuse	Other:
	Impaired parenting (mental illness)	

Behavioral Signs of Trauma:		
	Aggression towards self; self-harm	Sexual behaviors not typical for age
	Excessive aggression or violence towards others	Difficulty sleeping, eating, or toileting
	Explosive behavior (going from 0-100 instantly)	Social/developmental delays in comparison to peers
	Hyperactivity, distractibility, inattention	Repetitive violent and/or sexual play (or maltreatment themes)
	Excessively shy	Unpredictable/sudden changes in behavior (i.e., attention, play)
	Oppositional and/or defiant behavior	Other:

Emotional Signs of Trauma:		
	Excessive mood swings	Flat affect, very withdrawn, seems emotionally numb or “zoned out”
	Frequent, intense anger	Other:
	Chronic sadness, doesn’t seem to enjoy any activities, depressed mood	

Relational/Attachment Difficulties:		
	Lack of eye contact or avoids eye contact	Doesn’t reciprocate when hugged, smiled at, spoken to
	Sad or empty eyed appearance	Doesn’t seek comfort when hurt or frightened; shakes it off, or doesn’t seem to feel it
	Overly friendly with strangers (lack of appropriate stranger anxiety)	Has difficulty in preschool or daycare
	Vacillation between clinginess and disengagement and/or aggression	Other:

Children 6+

Known or Suspected Trauma Exposure:			
	Physical abuse		Exposure to drug activity (aside from parental use)
	Neglectful home environment		Prenatal exposure to alcohol/drugs or maternal stress during pregnancy
	Emotional abuse		Lengthy or multiple separations from a parent
	Exposure to domestic violence		Placement outside of the home (kinship care, foster care, residential)
	Exposure to other chronic violence		Loss of significant people, places, etc.
	Sexual abuse or exposure		Frequent/multiple moves; homelessness
	Parental substance abuse		Other:
	Impaired parenting (mental illness)		

Behavioral Signs of Trauma:			
	Aggression towards self; self-harm		Oppositional/defiant behavior
	Excessive aggression or violence towards others		Sexual behaviors not typical for age
	Explosive behavior (going from 0-100 instantly)		Difficulty sleeping, eating, or toileting
	Hyperactivity, distractibility, inattention		Social/developmental delays in comparison to peers
	Excessively shy		Other:

Emotional Signs of Trauma:			
	Excessive mood swings		Flat affect, very withdrawn, seems emotionally numb or "zoned out"
	Frequent, intense anger		Other:
	Chronic sadness, does not seem to enjoy any activities, depressed mood		

Difficulties in School:			
	Low or failing grades		Difficulty with authority/frequent behavior referrals
	Attention and/or memory problems		Other:
	Sudden changes in performance		

Relational/Attachment Difficulties:			
	Lack of eye contact or avoids eye contact		Does not seek adult help when hurt or frightened
	Lack of appropriate boundaries in relationships		Other: