Delaware Health & Social Services
Division of Developmental Disabilities Services
Community Services

PSYCHOLOGY DEPARTMENT REFERRAL FORM

NOTE: Please send all referrals to Dana Aurand

PERSON NEEDING REFERRAL: _____
Date of Referral: _____
Person and Agency Making Referral: _____

GENERAL INFORMATION:
Age: _____ Date of Birth: _____
Case Number: _____
Address: _____

RESIDENTIAL INFORMATION:
Where Does the Person Live?

_____Foster Care _____Staffed Apartment _____Group Home

_____Natural Family _____Other, please list _____

How long have they lived here? _____
If Neighborhood or ICF home, please state name of home: _____
_____
Name of the Contact Person where they live? (Staff/Provider/Family Member): _____
_____
_____
Telephone Number: _____

DAY SERVICES:
Where do they go during the day and how long have they been going there? (Day Program/Enclave/Work/School) (Be specific – ex: KSI):

_____
Contact Person/Title: _____Telephone #: _____

REASON FOR REFERRAL (attach sheet if additional information needed):
What is the person doing that concerns you?

_____
_____
_____
_____
_____
_____
_____
_____

How long has this been happening? _____

How frequently has this been happening? _____

When and Where does this typically happen? Work /home/community

What has been tried so far to correct the current problem?

Has this problem ever occurred before? If so, what was done about it in the past?

Is this situation potentially harmful to themselves or others? Yes No
If yes, how?

Have there been any changes in the person's life? (Any changes in where the person lives, health issues, other)
Yes No Don't Know
Explain

Does this person have a history of:

Taking a Medication to help behavior?	Yes	No	Don't Know
Going to a Psychiatrist?	Yes	No	Don't Know
Admission(s) to a psychiatric hospital?	Yes	No	Don't Know
Seeing someone for counseling?	Yes	No	Don't Know
Police Contact?	Yes	No	Don't Know
Ongoing Medical Issues?	Yes	No	Don't Know

If you checked "Yes" for any of these, please explain

When was their last visit to a general physician?

Have you talked to any Medical professionals to rule out any medical factors that could be causing/contributing to the problem? If so, what were the results of this?

Any Current Diagnoses and Medications?

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For Psychology Department Use Only

Date received by Psychology Supervisor:
Assigned BA/PA and Date sent:
Date received by BA/PA:
Initial Date of Contact with Case Manager:
Response date back to Psychology Supervisor:
Notes/Comments: