Hallmark Youthcare
12800 West Creek Parkway Richmond VA 23238
Phone 804-784-6432 Fax 804-784-5261

REFERRAL FORM

______ RTC (MEDICAID) ______TSAY _______ ASSESSMENT & DIAGNOSIS (CSA)

Referring Agency **Name Address Phone Email**	
Legal Guardian **Name Address Phone Email**	
Name of Resident	
Address of Resident	

Gender: Age: Birth Date: / / Birthplace: Race: Religious Preference:

Resident's Social Security Number		**Parents Right Terminated** (Circle One) YES NO

Resident Admitted From: (Circle One) **Home Hospital Detention Center Other**

IF other than home, please list:

Name: ____

Address/Phone:____

Reimbursement Source(s) (Please mark all that apply)

- □ VA Medicaid/Number: ____
- □ IV-E □ State Agency □ DC Medicaid/Number □ CSA
- □ Adoption Subsidy/Locality: ____
- □ School System ____
- □ Parents private Insurance: ____
  (Name and ID number)

IEP: ☐ YES ☐ NO ☐ OHI ☐ LD ☐ ED

Grade:_________ School:__________________ FSIQ:_____________ Date: ___/___/___

Please Include as much as possible of the following information:

- Most recent psychological evaluation, psychiatric evaluation.
- Discharge summaries from previous treating providers within last year.
- Social history-Family information-Foster care service plans.
- Documents with Information describing behavior within past 2 months (treatment plans, nursing/progress notes, progress summary reports) indicating medical necessity for secure RTC treatment.

List of treatment providers for the last 2 years:
(RTC, Group Homes, Intensive In home. Mentoring , CSB services, Out Patient Therapies)

Provider	Service	Start date- End date	Successful (Yes / No)	Reason for completion

Legal Charges **Supervised Probation:** ☐ YES ☐ NO **Name of Probation Officer:** ___________________

CHINS: ☐Supervision ☐Services Date: ____/____/____

Charge	Date	Disposition