1331 12th Ave, Suite 300 **Trauma Focused**

Altoona PA, 16601 **Cognitive Behavioral**

Office #: (814) 201-2751 **Therapy (TF-CBT)**

*\*Please send referrals to: Tessa McKay, LSW*

Email: tmckay@evolutionblair.com

Office #: (814) 201-2751 Fax #: (814) 201-2758

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| --- | --- | --- | --- | --- |
| **DATE OF REFERRAL** | **REFERRAL SOURCE** | | **REFERRAL CONTACT #** | |
|  |  | |  | |
| **MEDICAL ASSISTANCE #/ PRIMARY INSURANCE PROVIDER** | | | | |
|  | | | | |
| **CYF/JPO ASSIGNED STAFF** | | **PREFERRED COMMUNICATION** | | **PREFERRED CONTACT INFO** |
|  | | CELL / OFFICE PHONE / EMAIL | |  |
|  | | | | |
| **CYF/JPO ASSIGNED SUPERVISOR** | | **PREFERRED COMMUNICATION** | | **PREFERRED CONTACT INFO** |
|  | | CELL / OFFICE PHONE / EMAIL | |  |

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| --- | --- | --- |
| **PRIMARY ADOLESCENT** | | |
| **FULL NAME** | **DOB/ AGE** | **SSN** |
|  |  |  |
| **CIRCLE ONE: MALE/ FEMALE/ OTHER** |  | |
| **STREET ADDRESS** | **CITY, STATE and ZIP CODE** | |
|  |  | |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
|  |  |  |
| Who has legal custody of the adolescent? |  | |
| Where does the adolescent currently reside? |  | |

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| **REASON FOR REFERRAL- *Trauma(s) identified and symptom(s) occurring*** | | |
|  | | |
| **ADOLESCENT & FAMILY STRENGTHS** | | |
|  | | |
| **SERVICES CURRENTLY INVOLVED IN FAMILY** | | |
|  | | |
| **MENTAL HEALTH DIAGNOSIS** | | |
| Explanation: | | |
| Medication: | | |
| **SCHOOL INFORMATION** | | |
| School attending:  Current grade: | | |
| **FAMILY & HOUSEHOLD** | | |
| **Mother / Female Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  | |
| **Father / Male Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  | |
| **Number of siblings living in home** | **Other key supports** | |
|  |  | |

\*Feel free to attached additional info if necessary such as evaluations, school reports, or narrative info

Any additional info:

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