EARLY INTENSIVE BEHAVIORAL INTERVENTION PROGRAM at WPIC
REFERRAL FORM

1011 Bingham Street, 4th floor; Pittsburgh, PA 15203
Fax: 412.235.5387
Questions? Call Kate Fletcher 412.235.5315

*****Have you had the opportunity to review our detailed Program Guide: Overview of Treatment?***
☐ Yes ☐ No We strongly encourage you to review this guide so you have a clear understanding of our program. If you need a copy, please call our office at the above number. You may still submit a referral if you haven't reviewed but it is encouraged you take the time to review this information.

Demographic Information

Child's Name:	**Gender (circle) Male Female**
Child's Birth date: ___________________ **Age:_______________________________**	**Social Security Number (**required for insurance verification):_________________________________
Medical Assistance Number: **_______________________________** **☐ Application submitted, number pending**	**Residence (circle):** **Parents Foster Home Other____________**
Race (optional): African American Asian Caucasian Hispanic Indian Native American **Other:_____________________** **Native Language/language your child is most exposed to:___________________________________**	
Parent(s)/Guardian Name:	
Address:	**Phone: (Home)______________________** **(Cell) ________________________________** **(Work)_______________________________** **Email:_______________________________**
***When calling, may we leave a message at the above number(s) identifying our program? ☐ Yes ☐No** **Comments:**	

Family Information

Household Members (Name/Relation to child/Age):
Others Involved in Direct Care of Child (Name/Relation to child/Age)

Health Information

Any significant medical conditions? ☐ No ☐ Yes (Describe):__________________________________
____
____

Is your child taking any medications? ☐ **No** ☐ **Yes**

Medication **Dosage** **Prescribing Doctor**

____

____

Primary Care Physician (Doctor/Practice) ____

Address:________________________________

____

Phone:________________________________

Insurance Information

Act 62

Act 62 requires private health insurance companies to begin covering the costs of diagnostic assessments for autism and services for individuals with autism who are under the age of 21. It requires the PA Dept. of Public Welfare to cover the costs for individuals who have no insurance coverage or for individuals whose costs exceed $36,000 annually.

We will assist you in determining whether Act 62 applies to your child's insurance if you are not sure.

Does Act 62 apply to your child's insurance? ☐ **No** ☐ **Yes** ☐ **Not Sure**

Primary Insurance Information:	
Insurance Name:	**Renewal Date:**
ID Number:	**Group Number:**
Insurance Phone Number:	**Insurance Contact Name:**
Insurance Holder (subscriber) Name:	
Subscriber's SS #:	**Subscriber's DOB:**
Relationship to child:	

Clinical and Behavioral Information

Please provide your child's current diagnosis:

Axis I:________________________________

Axis II:________________________________

Axis III:________________________________

Axis IV:________________________________

Axis V:________________________________

****if you have a copy of a psychological evaluation, please feel free to include***

Communication

Communication Skills Is your child (circle) VERBAL NONVERBAL

(Describe):

____

____

____

Does your child use any other methods of communication? **(PECS, sign language, pulling adult to item, pointing, etc)**

(Describe):

____

____
____
____

Please share information on the following behaviors/situations and describe as best you can

Aggressions (hitting, kicking, biting, hair pulling, etc to self and/or others) ☐ No ☐ Yes (Describe):
____
____
____

Tantrums (intense crying/screaming, body flopping, etc) ☐ No ☐ Yes (Describe):
____
____
____

Fears/Anxiety ☐ No ☐ Yes (Describe):
____
____
____

Oppositional (refusal to follow instructions, argumentative) ☐ No ☐ Yes (Describe):
____
____
____

Mood Related Issues (depressive symptoms, tearfulness, irritability, mood swings, etc) ☐ No ☐ Yes (Describe):
____
____
____

Intense/Unusual Interests (spinning items, lining objects; focus on topics) ☐ No ☐ Yes (Describe):
____
____
____

Stereotypical Behaviors (handflapping, rocking, looking at items from different angles, etc) ☐ No ☐ Yes (Describe):
____
____
____

Property Destruction: ☐ No ☐ Yes (Describe):
____
____
____

Social Skills/Difficulties interacting with peers? ☐ No ☐ Yes (Describe):
____
____
____

Educational Issues ☐ No ☐ Yes (Describe):
____

Other Behavioral Concerns/Issues (Describe):

Overall Health and Self-Care

Feeding/Eating Issues (limited diet, GFCF, food tolerance, allergies, does child feed self? etc) ☐ No ☐ Yes (Describe):

Sleep Issues/Concerns ☐ No ☐ Yes (Describe sleep pattern):

Toileting/Potty Training (use pull ups/diapers, constipation/diarrhea issues) (Describe)

Any concerns regarding siblings? ☐ N/A ☐ No ☐ Yes (Describe):

CYF Involvement ☐ No ☐ Yes (Describe):

History of Abuse ☐ No ☐ Verbal ☐ Physical ☐ Sexual (Describe):

Drug and/or Alcohol Problems ☐ No ☐ Yes ☐ Child ☐ Family Member (Describe):

Other Comments/Information not noted above:

Child and Family Strengths

Child:

Family:____
____
____

LEVEL OF SERVICE/HOURS

REQUESTED LEVEL OF SERVICE **please fill out**
If you have a psychological evaluation prescribing wraparound/BHRS services, the hours would be noted
BSC ____ hrs/wk TSS ____ hrs/wk MT _____ hrs/wk
***prescriber, treatment team and family may determine final prescription of services**

TIMES/DAYS FAMILY IS AVAILABLE FOR SERVICE **(*this may differ from final team determination)**
Please fill in schedule below.

	MONDAY	TUESDAY	Wednesday	THURSDAY	FRIDAY
8:00a					
9:00a					
10:00a					
11:00a					
12:00p					
1:00p					
2:00p					
3:00p					
4:00p					
5:00p					
6:00p					

Location of service **(circle all that apply)** **HOME COMMUNITY SCHOOL** ______________________

Does your child nap? ☐ No ☐ Yes If yes, what times/how long?___________________________

How early can your child start a therapy session in the day? ___________________________________

Are there any limitations to your child's availability not noted above?___________________________
____

CURRENT SERVICES AND SERVICE HISTORY			
SERVICES RECEIVED	**AGENCY**	**CONTACT PERSON/ PHONE NUMBER**	**SERVICE DATES**
Case Management Services (examples include Alliance for Infants/Toddlers, Family Links, Mercy, Chartiers MH/MR, etc.)			
Crisis Services (ACES, Re:solve)			
CYF			
School Setting (examples include DART, preschool class, HeadStart, etc) ☐ Regular Education ☐ IEP ☐ Approved Private School ☐ Therapeutic School			
FBMHS (Family Based Mental Health Services)			
Inpatient Hospitalization			
Outpatient Therapy			
Therapeutic Services ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech ☐ Other			
Wraparound			
Other			