



CROSSROAD

Referral Form

2525 Lake Avenue
Fort Wayne, IN 46805
260.484.4153 phone
800.976.2306 toll-free
cgray@crossroad-fwch.org

Agency

Name:

Agency:

Address:

City, State, Zip:

Telephone:

Fax:

E-mail:

- Program Desired:
- | | |
|---|---|
| <input type="radio"/> Intensive Treatment | <input type="radio"/> Home-Based Services |
| <input type="radio"/> Diagnostic | <input type="radio"/> Day Educational Treatment |
| <input type="radio"/> Open Intensive Treatment | <input type="radio"/> Day Treatment |
| <input type="radio"/> Open Treatment | <input type="radio"/> Out-Patient Services |
| <input type="radio"/> Transitional & Independent Living | |

- How will you be sending supplemental information?
(Progress reports, IEP, Psychological Evaluations, etc.)
- Fax
 Mail
 Hand Deliver

Child

Name:

Date of Birth:

Sex:

Race:

- Current Status:
- | | |
|---------------------------|---------------------------------|
| <input type="radio"/> DOC | <input type="radio"/> Probation |
| <input type="radio"/> DOE | <input type="radio"/> Private |
| <input type="radio"/> OFC | <input type="radio"/> Other |

Reason for Referring:

Current Placement:

Current Diagnosis:

Who Made Diagnosis:

Date of Diagnosis:

Past Diagnosis:

Current Medications:

Last School Attended:

Grade:

IQ Scores:

Who Did Testing:

Date of Testing:



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History

Past Placements:

Abuse History: *(Please check all that apply and explain in the box below)*

- Out Patient Treatment
- Sexual Abuse
- Court Involvement
- Suicidal Ideation
- Physical Abuse
- Neglect
- Sexual Offender
- Delinquency

Explanation of Abuse(s):

Important Additional Information:

Family

Biological Rights Terminated? No One Parent
 Both Parents

Custodial Parent:

Father's Name:

Address:

Phone:

Mother's Name

Address:

Phone:

Siblings Name(s), Age(s), and
Residence:

***Please Note Additional Information May Be Required Upon Review.