SOUTHSTONE
Behavioral Health

REFERRAL FORM

3046 CARLBROOK ROAD, SOUTH BOSTON, VA 24592 - MAIN: 434-272-7050 – FAX 434-272-7085- _southstoneadmissions@acadiahealthcare.com

Referring Agency	**Name of Agency:** **Name:** **Email:** **Phone:**
Child/ Adolescent	**Name:** **Address:** **Age:** **DOB:** **Gender:** **SS#:** **POB:**
Custody	**Is this child in the custody of DSS?** ☐ YES ☐ NO **Have parental rights been terminated?** ☐ YES ☐ NO

Child / Adolescent's Current Placement: ☐ **Home** ☐ **Hospital** ☐ **Detention Center** ☐ **Other:** Click here to enter text.

If not home, where?

Address:

Reimbursement	☐ VA Medicaid/Number: ☐ CSA ☐ IV-E ☐ Adoption Subsidy/Locality: ☐ Private Insurance:

IEP: ☐ YES ☐ NO **If yes, date of current IEP:** _____ IEP **Disability Classification(s):** _____

Grade: School: FSIQ:

PLEASE ATTACH as much as possible of the following information:

- Most recent psychological evaluation and psychiatric evaluation.
- Discharge summaries from previous treatment providers within last year.
- Social history – Pre/Post Dispositional Report - 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 all treatment providers for the last 2 years:

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