Hampstead Hospital- Child Specialty Unit Referral Questionnaire

Name: ____________________________ Age: _______ Date: __________
Guardian: ______________________________ Insurance: ____________________________

Residence: ☐Home ☐Program: ____________________________
Patient is: ☐Verbal *☐Non-Verbal Language: ______________ Guardian's Language: ____________________
*If Patient is Non-Verbal do they use: ☐ Sign Language ☐ Picture Cues ☐ Communication Device
☐Other Please Explain: ____________________________
Can the Patient have a roommate? ☐Yes ☐No If No Reason? ____________________________
Self-Care/ADL: ☐Toilet Trained ☐Wears Diapers ☐Volitional Defecation ☐ Fecal Smearing ☐Volitional Urination
Current Height: __________ Weight: ___________
Assistive Devices (Glasses, Hearing Aids, Wheel Chair, Cane etc.) ☐ Yes ☐No If Yes Describe____________________________
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Presenting Behaviors:
Behaviors displayed at: ☐Home ☐ School ☐ Out in the Community
☐Use of Restraints ☐ Yes ☐ No If yes Frequency: ____________________
☐ Physical Aggression ☐Yes ☐ No If yes (☐ Punching ☐ Kicking ☐ Spitting ☐ Head-Butts ☐ Choking
☐ Other Please Explain____________________________)
☐ Self-Injurious Behavior ☐ Yes ☐ No If yes (☐ Head to Object ☐ Picking ☐ Biting Self ☐ Hitting Self
☐Other____________________________)
☐ Pica ☐Yes ☐ No ☐ Bolting/Elopement ☐ Yes ☐No
☐ Sexualized Behavior ☐Yes ☐ No If yes (☐ Sexualized Comments ☐ Disrobing ☐ Masturbating
☐ Inappropriate Touching ☐ HX of Sexual Perpetrating Behaviors)
☐ Suicidal Ideation ☐ Yes ☐ No ☐ Homicidal Ideation ☐ Yes ☐ No
☐ Psychosis ☐Yes ☐No ☐ Auditory/Visual Hallucinations ☐ Yes ☐ No
☐ Outburst, which may include (Yelling, Threatening, Banging on Objects) ☐ Property Destruction ☐ Yes ☐ No
☐ Other Notable Issues of Concern: ____________________________
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Peer Interactions: ☐ Mostly Appropriate ☐ Isolative ☐ Aggressive ☐ Antagonistic
☐ Other (Please Describe ____________________________)

Pre-Existing and/or current medical conditions:
☐ Denies ☐ Chronic Medical Condition____________________________
☐ Acute Medical Condition____________________________
☐ Other Medical Issues: ____________________________
☐ Seizure History: Frequency: ________________Date of Last Seizure: ____________________
☐ Recent Surgery ☐ Yes☐ No If Yes please explain____________________________
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Current Medication List: ____________________________
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Known Food and/or Drug Allergies:____________________________
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Date: ________
Status: ____
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Follow Up Needed: ____
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