Hampstead Hospital Child and Adolescent Specialty Services

Referral Questionnaire

Name: _____ Age: _____ Date: _____

Current Residence: _____

Patient's Guardian: _____ Relationship: _____

Reason for Referral/Description of Behaviors: _____

_____

_____

Patient's Current Height: _____ Patient's Current Weight: _____

	No	Yes	If Yes please describe/explain
Sexualized behaviors			
Assaultive behaviors			
Injury to others			
Self-injurious behaviors			
Assistance with ADL's			
Requires a single room			
History or current use of restraints			
History of placements or hospitalizations			
Current medical concerns/conditions			
History of medical concerns			
Patient's disposition plan is unknown			
Additional Information:			