Hampstead Hospital Child and Adolescent Referral Questionairre

Name:_____Age:_____Date:_____

Current Placement/Residence:_____

Patient's Guardian:_____Relationship:_____

Patient's Gender: Female_____ Male_____ Transgender _____

Patient's Current Height:			Patient's Current Weight:
Reason for Referral/Description of Behaviors:			
	No	Yes	If Yes please describe/explain
Sexualized behaviors			
Assaultive behaviors			
Injury to others			
Self-injurious behaviors			
Assistance with taking care of self (eating, bathing, etc.)			
Requires a single room			
History or current use of restraints			
History of placements or hospitalizations			
Current/History of medical conditions			
Legal involvement (past, current, or pending)			
Social skill concerns			
Academic concerns			
Will patient return to current residence after discharge? _____ Yes _____ No If not, what is the discharge plan?			
Additional information:			

_____ _____

Person Completing Form Date/Time Guardian Verification Signature Date/Time

Please fax completed questionnaire to (603) 329-9374

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