HERMITAGE HALL

"Turning over a new leaf"

Child's Information

Name:______________________________________ DOB:______________ SSN:______________________ Gender:______

Parent/Guardian Information

Name:______________________________________ Relationship to Child:____

Phone Number:_______________________________ Address:____

Person Completing Referral (if different from parent/guardian)

Name:______________________________________ Relationship to Child:____

Phone Number:_______________________________ Agency:____

Insurance Information

Primary Insurance Name:_______________________________ Member ID#:_____________________________________

Secondary Insurance Name:_____________________________ Member ID#:_____________________________________

How did you hear about us?

Referral Source Name:____

Agency:____ Phone Number:___________________________________

Is the child currently receiving any treatment (outpatient therapy, medication management, hospitalization, etc)?

Provider Name:_______________________________ Agency:____

Phone Number:_______________________________ Type of Service: ____

Does the child have any legal charges? Yes_____ No_____

Probation Officer Name:____ County:___________________________________

Phone Number:_____________________________________ Charges:____

Has the child experienced any traumatic event or abuse? Yes_____ No_____ If yes, please describe:

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Please describe the child's current behaviors and reason for referral.

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Does the child have any current or past medical issues? Yes_____ No_____ If yes, please describe:

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Please fax completed application to 615-250-2388 or email to Melissa.Williams@uhsinc.com or Sarah.Cimbalista@uhsinc.com