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:

_____

_____

_____

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

_____

_____

_____

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

_____

_____