UNIVERSITY of MARYLAND SCHOOL OF MEDICINE

ADULT REFERRAL FORM

Date of Call/Referral: ________

THE CARE CLINIC AT THE UNIVERSITY OF MARYLAND CENTER FOR FAMILIES

Referrals can be made via phone at **410-706-4869**; via fax at **410-706-3017**; or via email to **careclinicreferrals@peds.umaryland.edu**

Name of Referred: __________________________ DOB: ___________________________________

Gender: ○Male ○Female ○Other ______________ Race/Ethnicity: ____________________________

Secondary Victim(s) Names and DOB: ____

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Address: ______________________________________ City: ______________ State: _______________

Zip code: ___________ County: ___________________ Phone Number: __________________________

Email Address: ____

Emergency Contact Name: ____

Address: ____ City: _________________________

State: ______________ Zip code: _____________ Phone Number: ______________________________

Email Address: ____

Referral Source

Name: ________________________________ Agency: ____

Address: ____ City: ________________________

State: ______________ Zip code: _____________ Phone Number: ______________________________

Fax Number: ______________________ Email Address: _______________________________________

Other Agencies Involved:

Name: ______________________________________ Agency: __________________________________

Email Address: ____

Phone Number: _____________________ Fax Number: ___________________________________

Medical Issues: _______________________________ Medications: ______________________________

(See other side)

Type of Abuse: (check all that apply)

○Sexual Abuse ○Physical Abuse ○Neglect ○Domestic Violence ○Sex Trafficking

Alleged Perpetrator & Relationship: ____

Date of Incident: ___________________ Date of Incident Disclosure: __________________________

Reason for Referral (brief summary of observed behavioral problems, symptoms, etc.)

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Symptoms: (please check all that apply)

○ Fire setting	○ Abuse of animals	○ Psychiatric hospitalizations
○ Suicidal gestures or ideation	○ Violence toward others	○ Speech/developmental delays
○ Psychosis	○ Sexual behavioral concerns	○ Physical aggression
○ Drug/alcohol abuse	○ Sleep disorders	○ Nightmares/flashbacks
○ Hallucinations	○ Academic concerns	○ Work-related problems
○ Anxiety	○ Depression	○ Irritability
○ Disordered eating	○ Low self-esteem	○ Mood fluctuation

Is the individual currently in treatment? ○Yes ○No

If yes, list where & explain reason for treatment:

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Type(s) of Services requesting: (please check all that apply)

○ Intake Evaluation (diagnosis, treatment recommendations)

○ Individual Therapy ○ Group Therapy ○ Family/Couple Therapy

○ Psychological Evaluation (for academic/cognitive functioning)

○ Psychiatric Evaluation **(<u>only for care clinic clients</u>)**

*The Care Clinic does NOT provide forensic assessments.