Nexus-Gerard
FAMILY HEALING

Check which service is being requested:

☐ Long-Term Treatment ☐ Short-Term Treatment ☐ 45-Day Assessment ☐ CIBS Program

Date of Referral:_____ Referral Source:_____

YOUTH INFORMATION

Youth's Full Name:_____

Date of Birth:_____ Birth Place:_____

Gender:_____ Nickname:_____

Race:_____ HT:_____ WT:_____

Religion:_____ Hair Color:_____ Eye Color:_____

# of Siblings:_____

Youth's Current Placement:_____

_____

Previous Hospitalizations (hospital & dates):_____

_____

Youth's Primary Reasons for Needing Placement:_____

_____

_____

Psychiatric Diagnosis:_____

_____

Date of Last Diagnostic Assessment:_____

Current Medications:_____

_____

Medical Diagnosis:_____

Allergies:_____

Food Restrictions: _____

Physical Disabilities:_____

Family Doctor:_____

Clinic:_____ Phone:_____

Current Grade:_____ Last Known IQ:_____ IEP: Yes☐ NO☐

School District Name & Number:_____

Contact:_____ Phone:_____

Referring Agency Information

Referral Agent:_____

Agency Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ Work Cell:_____ Fax:_____

Email:_____

Family Information

Father:_____ Level of Involvement:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

DOB:_____

Mother:_____ Level of Involvement:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

DOB:_____

Funding Information

Funding Agency:_____

Insurance:_____ PMAP:_____ MA:_____ MA number:_____

Name of Insurance Company:_____ Phone:_____

Group#:_____ ID:_____

Name & DOB of Insured:_____

Relationship to Youth:_____