The Institute for Behavior Change

FAX to our secure, confidential line at **610-524-8705** **MAIL to:** **IBC**
120 E. Uwchlan Ave. Suite 202
Exton, PA 19341-1275

Referral Source

Referral Source: _____ Referral Date: _____ Referral phone: _____

Relationship to Child: _____ Referral Fax: _____

Child and Family Information

Child's Name: _____ DOB: _____ SSN: _____

Child's Age: _____ Gender: _____ Ethnicity: _____ Primary Language: _____

Child's Address: _____
Street City State Zip

County of Residence: _____ Pediatrician: _____ Phone: _____

Parent/Guardian: _____ Home Phone:_____Cell Phone: _____

Parent/Guardian: _____ Home Phone:_____ Cell Phone: _____

What is the best way to contact you: _____

Legal Custody Arrangement: _____

Primary Health Insurance: _____ Policy #: _____ Group #: _____

Medical Assistance: ☐ Yes ☐ No Medical Assistance Number: _____

Reason for Referral

Reason for Referral (use the Tab key to move to the next row if you are filling this form out with a computer):

_____

_____

_____

_____

_____

_____

Check all that apply: ☐ Aggressive toward Adults ☐ Aggressive toward Peers ☐ Places self in danger

☐ DHS/CYF Client ☐ Suicide attempt ☐Cognitive Impairment ☐ School Problems ☐ Drug Abuse

☐ Alcohol Abuse ☐ Autism Spectrum ☐ Legal involvement ☐ Currently in Hospital or Residential Treatment

Current Medication & Dosages: _____

_____

Medical Conditions: _____

How Did you Hear of Us: _____

Office Use Only

Date Received: _____ EVS Date: _____ Screening Date: _____ BSCs: _____ Date Assigned: _____