CENTER FOR PSYCHOLOGICAL ASSESSMENT AND TREATMENT (CPAT)

Intake and Referral Form

Individual Information

Name:	Date of Birth:
Support Coordinator: Contact Information:	Support Coordination Agency: Contact Information
Services Requested: _____**DAY PROGRAM** Circle Days you wish to participate in Day Program: M TU W Th F _____**BEHAVIORAL SUPPORTS** List concerning behaviors: _____ _____**PSYCHODIAGNOSTICS** (i.e., Forensic; IQ; Psychosexual; Psychological; Behavioral; Custody/Parenting) _____**PSYCHOTHERAPY/COUNSELING** Briefly explain need _____ _____**JUVENILE SERVICES**: Briefly explain _____	
Past Day Programs/School(s) Attended:	
Current Daily Activities (i.e., Job Coaching/Working/Day Habilitation/Community Inclusion, etc.)	
Individual Contact Number:	Message ok? ❒ Yes ❒ No
Individual DD Medicaid Number:	

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers: ❒ Foster Home ❒ Psychiatric hospital ❒ Other	Type of setting: ❒ Home ❒ Group Home

Any Court Involvement: (circle) Y N (If yes, please discuss directly with CPAT Executive Director)

Please describe or detail any health concerns:

Please describe or detail current presenting behavior problems (be sure to note if there are any inappropriate sexual behaviors; aggression; and substance use/abuse.

Mental Health Information:

Current medication & dosage	Current Diagnosis – If known
	Axis I
	Axis II

BEHAVIORAL AND MENTAL HEALTH ISSUES:

PRESENTING ISSUES/SYMPTOMS:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Hallucinations (describe)					
Delusions					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit issues					
Eating problems					
Oppositional / defiant to those in authority					
Antisocial / Conduct disorder					
Sexually disordered behavior					
Somatic complaints with no known medical cause					

Attachment issues (explain below)					
Aggression					
Self-harming Behaviors					
Suicidality					
Victim of Abuse					
Other (explain)					

Details for responses above – if applicable

_____

_____

Additional Comments _____

_____

Individual Completing Form:_____ **Date**: _____

Staff Reviewing Form:_____ **Date**: _____