

Diagnostic Information:

Primary Mental Health Diagnosis Code and Description:

Additional Mental Health Diagnoses:

Primary Medical Diagnosis (if applicable):

System Involvement:

Mental Health Outpatient Involvement
If yes, Agency Name(s) & Contact Info:

Probation Involvement
If yes, PO's Contact Info: _____

Children & Youth Involvement
If yes, CYS Contact Info: _____

Office of Intellectual Disabilities Involvement
If yes, OID Contact Info: _____

Drug & Alcohol Treatment
If yes, D&A Contact Info: _____

Collateral Information/Documentation:

Please check any collateral documents being provided for additional information:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Psychosocial History | <input type="checkbox"/> Summary of Treatment |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Educational Records | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Other: |

Referral Source's Information:

Young Person/ Self-Referral

Natural Support

Referring Person's Name:

Referring Person's Phone #:

Does the young person want to participate in ENGAGE?

Formal Support

Name of Referring Person's Affiliation:

Referring Person's Name:

Referring Person's Phone #:

Does the young person want to participate in ENGAGE?

*Release of Information signed by young person and attached? Yes No

The following information MUST be answered by the Referral Source:

Is the young person aware of and in agreement with referral?

Yes

No

Comments:

Reason for referral:

Indicate the degree to which the young person's family/caregiver is involved with treatment:

Low

Medium

High

Comments:

Please describe the psychotic symptoms that the young person has reported and/or demonstrated within the past 12 months (include the date of onset and course of qualifying symptoms if known, any self-harm, suicide attempts, or violent behavior):

I understand that submitting this ENGAGE referral does not guarantee enrollment into the ENGAGE program.

Young Person's Signature (if applicable)

Date

Referring Party's Signature (if applicable)

Date

Please submit the complete referral and related materials to:

ENGAGE Program Attn: George Corona LSW, CPRP

Fax: (412) 412-436-4306

Giorgio.corona@wfspa.org