

# WESLEY FAMILY SERVICES EXTERNAL REFERRAL FORM

**Date of Referral:** \_\_\_\_\_

**County:** \_\_\_\_\_

Please send completed referral form to Central Access Department at\*

(Fax) 412-347-3237 or (Email) [CAEmailFax@wfspa.org](mailto:CAEmailFax@wfspa.org)

## Client Information

Name:		Date of birth:	
Social Security Number:		Age:	
Race:	Gender:	Prior WFS client? <b>Y</b> <b>N</b> if yes, what was program?	
Current Address:			
Court ordered to receive treatment: <b>Y</b> <b>N</b>		CYF Involvement: <b>Y</b> <b>N</b>	

## Insurance Information

Primary Insurance:	Secondary Insurance:
Policy# or MA#:	Policy# or MA#:

## Parent/Caregiver Information

Legal Guardian name and relation to client:	
Home phone:	Cell phone:
E-mail address:	Emergency Contact(s):
Who has Legal custody of Child?	Are there Custody Documents? <b>Y</b> <b>N</b> (if so please provide a copy)

## Program(s) Referring to:

<input type="checkbox"/> ASD/MH OP Therapy <input type="checkbox"/> 3-Day Diagnostic Testing (formerly known as CARES) <input type="checkbox"/> Creative Arts (CA) <input type="checkbox"/> Healthy Relationships (HR) Groups <input type="checkbox"/> Other: _____	<input type="checkbox"/> MH IOP (New Kensington Only) <input type="checkbox"/> Parent-Child Interaction Therapy (PCIT) <input type="checkbox"/> Psychological Evaluations / Written Order <input type="checkbox"/> Psychiatric Evaluations/ Med Management <input type="checkbox"/> Young Learners (YL) Group
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## Program(s) that require additional documents attached

<input type="checkbox"/> IBHS – Attach the Written Order recommending IBHS <input type="checkbox"/> Intensive Family Coaching (IFC)-Attach the Written Order recommending IFC <small>(Client cannot have ASD and must have CCBHO to receive IFC)</small> <input type="checkbox"/> Wonder Kids (WK) – Attach the Written Order recommending WK/IBHS Group Services
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## Location(s) Referring to:

<input type="checkbox"/> Bridgeville <input type="checkbox"/> Monroeville <input type="checkbox"/> New Kensington (Pioneer) <input type="checkbox"/> Tarentum	<input type="checkbox"/> Washington <input type="checkbox"/> Wexford <input type="checkbox"/> WFS K-8 (JRB) <input type="checkbox"/> WFS High School (Caste)
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**Continued on Back**

<b>Referral Source</b>	
Name:	Agency:
Phone Number/Email:	Role:

<b>Presenting Problem(s)/Reason for Referral:</b>

\*Please fax this completed form to 412-347-3237. If you wish to email, WFS cannot safely guarantee your information will not be compromised.