OPEN ROADS SERVICES, LLC (518298)

Referral Form Fax (877) 744 – 8986 Office (973) 388-4751

Youth's Name: _____ **DOB:** _____ **Cyber#:**_____

Medicaid #: _____**Social Security #:** _____ **Age:**_____ **Gender:**_____

Guardian's Name: _____ **Relationship to youth:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone numbers: **Youth:** _____ **Caregiver:** _____

Emails: **Youth:** _____ **Caregiver:** _____

Spanish Speaking Provider Required: **Youth:** ☐Yes ☐No **Caregiver:** ☐Yes ☐No

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REFERRAL REASON(S) & HISTORY OF PRESENTING PROBLEMS (CHECK ALL THAT APPLY)

❒ Anxiety	❒ DDD	❒ Gender Identity	❒ School issues / Truancy
❒ ASD	❒ Defiant/Oppositional	❒ Homicidal ideation	❒ Sleep disorders
❒ Conflict – w/ parents	❒ Depression	❒ Hyperactivity	❒ Suicidal Ideation
❒ Conflict – w/ placement	❒ Eating disorder	❒ Runaway history	❒ Other_____

SERVICE TYPE	CHECK BOX	CODE	DATES OF SERVICES	HRS / WEEK
IIC - MASTERS LEVEL		**H0036TJU2**		
IIC - MASTERS LEVEL – ARC GROW		**H0036TJU2**		
IIC - LICENSE LEVEL		**H0036TJU1**		

REFERRED BY: **AGENCY:** _____

CASE MGR.: _____

OFFICE: (_____)_____ **FAX:** (_____)_____

Referral approved by:_____ **Date:**_____