REFERRAL FORM

CHILDREN & YOUTH SERVICES

Campbell
PSYCHOLOGICAL SERVICES

Return via fax to (717) 620-0536 or mail to 25 East North Street, Carlisle, PA 17013
Please don't hesitate to call with any questions: (717) 422-6440

CHECK ONE

☐Family will contact Campbell Psychological Services to request services
☐Please contact caseworker to discuss scheduling

CLIENT

Child's Name: _____ DOB: _____

Gender: _____ Age: _____ Grade: _____ School: _____

Address: _____

Is English the primary language of the youth? ☐Yes ☐No

CHILDREN & YOUTH INFORMATION

Contact Person / Caseworker: _____

Phone: _____ Email: _____

Best time(s) to reach you: _____

How long as CYS been involved with this youth/family? _____

Current status of CYS involvement: _____

CUSTODY / LIVING SITUATION

Consistent with Pennsylvania law and guidance from Pa. Psychological Association, the individuals or entity with legal custody of the child must provide consent before psychological treatment is provided to children 13 and under. If two or more individuals share legal custody of the child, all must provide consent. Youth 14+ can consent to their own treatment and control their treatment records. Authorization is needed from a legal guardian or the client (if 14+) before we can release any information to Children & Youth Services.

Who has legal custody of this child? _____

Address: _____

Phone: _____ Relationship to child: _____

**If applicable, please provide a copy of the custody order.*

With whom does the child live?

☐Same as above

Name:_____

Address: _____

Phone: _____ Relationship to child: _____

Who will be responsible for scheduling and keeping appointments for this child?

Name:_____

Phone: _____ Relationship to child: _____

REASON FOR REFERRAL

☐ *Psychological Evaluation:* What question or concern do you hope will be addressed by the evaluation? Is there a specific date by which the evaluation is needed? ☐No ☐Yes - date: _____ Is this evaluation court-ordered? ☐No ☐Yes (please attach copy of the order)
☐ *Therapy:* What issues or concerns are prompting this referral?

INSURANCE (if known)

☐Medical Assistance ☐Highmark Blue Shield ☐Capital Blue Cross (no CHIP)
☐Other Blue Cross/Blue Shield ☐UPMC
☐Tricare (please note we are *not* in-network, so point- of-service fees may apply)
☐Other*: _____***If you select other, the client will need to self-pay and seek reimbursement from insurance for out-of-network coverage***

Is this a CHIP Plan? ☐Yes ☐No ☐I don't know

THANK YOU!