Recognizing Children's Gifts
State Services

Behavioral Consultation Referral Form

Phone: (804) 897-1797 Fax: (888) 489-4526 Email: info@rcghealthnetwork.com
www.rcghealthnetwork.com

Directions: To be completed by the Service Coordinator, Case Manager, or Family Member and submitted by fax or email

Date: _____
Referred Individual's Name: _____
Date of Birth: _____
Address: _____ Phone #:_____

Does this person have a legal guardian? ❒Yes ❒No
If yes, provide guardian information: _____

***Funding Source:** Please check all that apply

CSA	Schools	IFSP	Private Pay	DD Waiver*		Other
				Community Living	Family and Individual Supports	

*If Waiver referral, Medicaid#: _____

*If Waiver referral, PCP Start/End Dates: _____

Reason for referral :

Area(s) of need: Please check all that apply

Independence		Communication		Community Participation		Behaviors	
Food Prep		Expressing wants/needs		Employment		Aggression	
Grooming		Expressing frustrations		Limited community outings		Self-Injury	
Following a schedule		Advocating for self		Safe transportation		Property Destruction	
Independent work tasks		Interacting with peers/co-workers		Day Support		Elopement	
Independent Leisure Skills		Follow directions		Training for support staff		Repetitive Behaviors	

Please provide any additional information below (please list specific behavior/substance abuse concerns):

_____
_____
_____
_____

Diagnoses (must also include level of ID): _____
_____

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Requested Location of Services:

Requesting services at the following locations and with the following support providers (please include guardian information even if services are not being requested at that location):

Home: Contact Person: _____ Phone#: _____

*Relationship to individual: _____

Address: _____

*Provider Name (if applicable): _____

Other: Contact Person: _____ Phone#: _____

*Relationship to individual: _____

Address: _____

*Provider Name: _____

Other: Contact Person: _____ Phone#:_____

*Relationship to individual: _____

Address: _____

*Provider Name: _____

Please fill out the below availability schedule. In the corresponding boxes, write the **exact time** you are available for services. This will be used for appointment scheduling.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
Location					
PM					
Location					

_____ _____

Service Coordinator/Parent/Guardian Name/Signature ***Date***

_____ _____ _____

Direct Phone # ***Fax #*** ***Email address***