Referral to:	Student's Name:		Gender:	DOB:	Date of Referral:
Orange Intensive Day Treatment 4 Harriman Drive Goshen, NY 10924 Phone: 845-615-0224 Fax: rcpc-OrangeIDT-Fax@omh.ny.gov	Address:				Home Phone:
					Cell Phone:
	Parent/Guardian's Name:		Parent/Guardian Email:		Work Phone:
	School Liaison Name/Title:		Liaison's Email:		Liaison's Phone:
	Student's Guidance Counselor:		Guidance Counselor's Email:		Guidance Counselor's Phone:
	School District:		Parent/Guardian Preferred Language:		Student's Preferred Language:
	Grade	Special Education Y N	Please Circle: LD ED 504		
	Please include immunization records, a copy of the student's physical exam, schedule, report card, 504/IEP, and disciplinary reports, in addition to consent with this referral.				

1. Please provide reason for referral:

2. How was the student functioning prior to the crisis both academically and behaviorally? Does the student have a history of disciplinary concerns? If so, please include records in referral.

3. Please describe previous attempts at problem solving:

4. Please describe family involvement:

5. Please indicate suspicion of physical abuse, sexual abuse, neglect, and/or substance use/abuse:

6. Please describe current counseling (school/private) and medication, identify other agencies involved i.e., social, legal:

School-based counseling:

Outpatient therapist:

Psychiatrist:

Care Manager:

Other Services:

Medications:

7. Please describe academic plan following discharge from IDT: