STRIVE
REFERRAL FORM

4701 Fairway Avenue
North Little Rock, AR 72116
Phone: (501) 771-8261
Fax: (501) 771-8263

Date of Referral: ________________ Referral Source: ________________ School Name: ___________________________

School Phone Number: ________________________ Grade: ______________ Primary Language:_____________________

Student's Name: _________________________________ Date of Birth: _______________ Age: ______ Gender: M or F

Social Security #: _________________________ Race: (W) (B/AA) (H/L) (NA/AI) (A/PI) Other: _______

Is the child in DHS/DCFS custody? Yes or No | Is the child in Foster Care? Yes or No | Former STRIVE Patient? Yes or No

---

Medicaid/AR Kids 1st #: __________________ Eligibility (date): ____________________

Insurance Company: ____________________________________ Policy #: ____________________________

Name Insurance is Under: __________________________________ Group #:__________________________

Date of Birth of Insurer: ___________________ Insurer Social Security #: _____________________________

Primary Care Physician's Name: ____Phone: __________________

(Tier 1 - must obtain referral from PCP)

Reason for referral or concerns:

_____ Short Attention Span	_____ Poor Anger Control	_____ Sadness	_____ Anxiety (worries)
_____ Impulsivity	_____ Destructiveness	_____ Isolation	_____ Abuse - Sexual or Physical
_____ Hyperactivity	_____ Aggression	_____ Self-Injurious Behavior	_____ Behavior Issues

Please list any present or past mental health counseling, medication treatment, testing, previous diagnosis, court involvement:

____

____

Parent/Legal Guardian: ______________________________________ Relationship to Child: ______________________

First Middle Initial Last

Address: ____

Street City/State Zip Code

Parent Social Security #:________________________ Parent DOB:________________________

Cell Phone: ___________________ Email Address: ____

Employer: ____________________Business phone: _________________________

Emergency Contact Info: :_______________________________ _____________________________

Name Phone

Parent/Legal Guardian Signature: ____

(**Permission to Process Referral**)

Fax Completed Referral to 501-771-8263