



Today's Date: \_\_\_\_\_

## Infant and Early Childhood Mental Health Referral Form

### Check Eligibility Criteria

- Client is between the ages of 0 through 5, or currently pregnant
- Client resides in Ada, Boise, Canyon, Gem, Elmore or Valley County (Please circle which county)
- There is a need for assessment of a mental health diagnosis, or client has previously been diagnosed

### Client Information

Client's Name: \_\_\_\_\_ Insurance:  Yes  No  
 Legal Guardian Name: \_\_\_\_\_ If yes, type: \_\_\_\_\_  
 Language: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Is the client currently participating in any therapy or behavioral health services?  Yes  No

### Referral Source

Referring Source Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Referring Organization: \_\_\_\_\_ Fax: \_\_\_\_\_

{Provide fax number that you would like follow up to be sent to}

### Comments/Concerns:

Release of Information Attached (for referral source or organization):  Yes  No

Fax completed Referral Form and Release of Information to 208-321-2331