NEW LIGHT RESIDENTIAL TREATMENT CENTER FOR YOUTH INC

INFO@NEWLIGHTRTC.ORG

RESIDENTIAL TREATMENT REFERRAL FORM

1. YOUTH DEMOGRAPHICS

Full Name: __________________________ DOB: __/__/__ Age: __
Medicaid ID: ___________________ Guardian: _________________
Address: _______________________ Phone: ____________________

2. REFERRAL SOURCE

Provider: ______________________ Credentials: _________________
Agency: ________________________ Phone/Fax: _________________
Referral Date: __/__/__

3. PRESENTING PROBLEMS (check all)

☐ Suicidal ideation/attempts ☐ Non-Suicidal Self-harm ☐ Physical Aggression Toward Others
☐ Substance use ☐ Runaway ☐ School expulsion/Safety Concerns
☐ CPS/DFS involvement ☐ Prior placement failure
☐ Other: ______________________________

4. TREATMENT HISTORY (Past 12 months)

Psych Hospitalizations (#____ Dates: ___________)
Crisis Center Stays (#____ Dates: ___________)
IOP/PHP Programs: ___________________________
Prior RTC Placement: ________________________
Current Outpatient Provider: _________________

5. CURRENT STATUS

Diagnosis: _____________________ ICD Code: ________
Current Medications: _________________
Legal: ☐ Voluntary ☐ Court-ordered Case#: _____________

6. MEDICAL NECESSITY JUSTIFICATION

Why residential level of care is required (less restrictive alternatives failed):

REFERRING PROVIDER CERTIFICATION

"I certify this 12-17yo requires residential behavioral health treatment due to imminent risk and failure of community-based interventions."
Provider Signature: ______________________ Date: __/__/___
Printed Name/Title: _____________________ License #: ________

New Light RTC | Pre-Licensing Referrals Welcome | HHSC Application Pending

**SUBMIT SECURELY: ** referrals@newlightrtc.org

Behavioral Health Residential