## Patient Information and Referral Sheet

### Patient Information:
- **Gender:** M / F
- **Age:** _______ years ______ months
- **City of residence:**
- **Zip code:**
- **Primary language (caregiver):**
  - English
  - Spanish
  - Somali
  - Hmong
  - Other: (specify)
  - Unknown
- **Race/Ethnicity:** (check all that apply)
  - African-American
  - Asian
  - Native American
  - White/Caucasian
  - Hispanic/Latino
- **Type of Insurance:**
  - Medical Assistance
  - BC/BS
  - HMO/MCO
  - Private Pay
  - No insurance
  - Other: (specify)

### Screening Information:
- **Date of screening:** ____/____/______
- **ASQ:SE Version Used (Age, Language):** ________________________________
- **ASQ: SE Score:** __________
- **Elevated?** YES / NO

### Referral Information:
- **Physician referral:**
  - mental health assessment
  - medical assessment
  - parenting class/support group
  - no referral
  - other (specify): ________________
- **Notes:**

### Mental Health Assessment Information:
- **Date of Assessment:** ____/____/______
- **Diagnosis:** ________________________________
- **Intervention:**
  - child - individual therapy
  - child – medication evaluation
  - child and parent – family therapy
  - child and parent – Early Head Start
  - parent – parenting classes
  - parent – individual therapy
  - other: ________________________________