BEST POINT
EDUCATION & BEHAVIORAL HEALTH
Empowering individuals. Transforming communities.

REFERRAL FORM

General Information

Date of Referral: _____
MM/DD/YYYY

Was permission received from the child's parent/guardian to submit this referral? ☐ Yes ☐ No

NOTE: permission from the child's parent or guardian must be obtained before submitting this referral to Best Point.

Person Making the Referral: _____ Referrer's Phone Number: _____
First and Last Name (###) ###-####

Referrer's Email Address: _____ Referring Entity: _____
example@example.com Name of school, clinic, hospital, agency, etc.; If the parent/guardian, enter "Self"

Requested Service(s)

Autism Services
- ☐ Applied Behavior Analysis
- ☐ Heidt School* (grades 6-12)
- ☐ Heidt Transition Program (ages 18-21)

Best Point Schools* (grades k-12)
- ☐ Butler County
- ☐ Hamilton County

Care Coordination (ages 3-18)
- ☐ Butler County
- ☐ Hamilton County

Day Treatment on Best Point Campus (grades PreK-12)
- ☐ Butler County
- ☐ Hamilton County

Medical Management Services
- ☐ Butler County
- ☐ Hamilton County

Office-Based Behavioral Health Counseling (ages 3-8)
- ☐ Butler County
- ☐ Hamilton County

- ☐ Afterschool Program CATS (grades 9-12)
- ☐ Alcohol and Drug Counseling
- ☐ School-Based Behavioral Health Counseling (Ages 3-18 where available)
- ☐ School-Based Day Treatment (Grades K-12 where available)

*An Individualized Education Plan (IEP) & Evaluation Team Report (ETR) are required for referrals to Best Point & Heidt Schools.

*A transcript is required for high school students referred to Best Point schools.

- For referrals to behavioral health services, please submit available documents.
- Documents can be emailed to referrals@bestpoint.org

Child's Information

Child's Legal Name: _____ Child's DOB: _____ Child's SSN: _____
First and Last Name MM/DD/YYYY ###-##-####

Child's Address: _____ _____ _____ _____
Street Address City State Zip Code

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Unknown

Child's Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Biracial/Multiracial ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Name of Child's School: _____ Child's Grade: _____
School Name Grade

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to Child: _____ Phone: _____
First and Last Name i.e.: mother, aunt, father (###) ###-####

Address: _____ _____ _____ _____
Street Address City State Zip Code

Insurance Information

What type of insurance does the child have? ☐ Medicaid ☐ Commercial ☐ Unknown ☐ Both Medicaid and Commercial

Complete this section if selected 'Medicaid' or 'Both'

Select Medicaid Plan: ☐ Aetna ☐ CareSource ☐ Paramount ☐ Buckeye ☐ Molina ☐ United Healthcare

Other: _____ (Please specify)

Medicaid Number (MMIS): _____ (12 Digits)

Medicaid Member ID: _____ (11 Digits)

Complete this section if selected 'Commercial' or 'Both'

Commercial Insurance Provider: _____ (Provider)

Policy #: _____ (Policy Number) Group #: _____ (Group Number)

Policy Holder Name: _____ (First and Last Name)

DOB: _____ (MM/DD/YYYY) Relationship to Child: _____ (i.e.: mother, father)

Symptoms/Behaviors

Please mark any symptoms or behaviors that apply to this child:

- ☐ Angry outbursts; rage; tantrums
- ☐ Crying excessively
- ☐ Fighting
- ☐ Verbally abusive or aggressive
- ☐ Does not accept responsibility for behavior
- ☐ Poor peer relationships
- ☐ Depressed; sad; tearful
- ☐ Anxious; nervous; restless; fearful
- ☐ Death of a loved one; loss; separation
- ☐ Hyperactive; restless; cannot sit still
- ☐ Irritable
- ☐ Limited range of emotions
- ☐ Lacks empathy
- ☐ Hoarding or gorging food
- ☐ Stealing
- ☐ Short attention span; easily distracted
- ☐ Disruptive; attention seeking
- ☐ Low self-esteem; poor social skills
- ☐ Defiant; refuses to follow the rules
- ☐ Impulsive; does not think about consequences
- ☐ Hostile; agitated; intimidating; aggressive
- ☐ No eye contact; unkempt; disheveled
- ☐ Lies; exaggerates; triangulates
- ☐ Sexually inappropriate behavior/focus
- ☐ Exaggerated startle response
- ☐ Persistent and unrealistic worry/fears
- ☐ Other: _____ (List other here)

Suicidal/Homicidal Ideation

Is there current concern regarding suicidal ideation? ☐ Yes ☐ No ☐ Unknown

Is there current concern regarding homicidal ideation or desire to seriously harm another person? ☐ Yes ☐ No ☐ Unknown

If you answered 'YES' to either question above, take immediate action by contacting our intake office at (513) 272-2800. If there is immediate danger, go to the nearest hospital or call 911.

Substance Abuse

Is there a concern regarding substance abuse? ☐ Yes ☐ No ☐ Unknown

Description of Child's Behaviors/Symptoms

Please describe the child's behaviors, symptoms, and/or other concerns:

_____

_____

_____

_____

_____

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Please submit this referral to referrals@bestpoint.org or complete the online referral form at bestpoint.org/referral