
**Agency use only**

☐ meets criteria for Lehigh county contract:

-resides in Lehigh County or is planning to return to the county within 90 days of making referral

-identified youth ages 8-21

-mental health diagnosis

***Primary Axis I Autism Spectrum disorders are not eligible.** *

# High Fidelity Wraparound Referral Form

| | | |
|---|---|---|
| Referral Agent: | Date: | |
| Referring Agency: | Phone: | Other: |
| Address: | City: | Zip: |
| | | |

**FAMILY INFORMATION:**

| | | |
|---|---|---|
| Family Name: | Phone: | Other Phone: |
| Address: | City: | Zip: |

**DESCRIPTION OF FAMILY MEMBERS:**

| IY | Name | Relation i.e. mother, son, father, daughter... | Date of Birth | Age | SSN# | Mental Health dx. or Substance Use -Describe: |
|---|---|---|---|---|---|---|
| **X** | | | | | | |
| | | | [redacted] | | | |
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Please describe in **specific behaviors** what makes the family/child appropriate for home visits/HFW process.

**Strengths:**

**Supports**:

**Service Providers**:

**Needs/Concerns**:

**Safety Concerns** (past and present):

**Multiple placements or at risk of placement (hospitalization):**

**Medical Assistance #:**

| |
|---|
| Alternative services attempted: |
| Does the family need services in a language other than English? |

**Fax: (610) 740-9550 Attn: HFW Supervisor**

**Documentation of all contacts:** Date: (month/day/year), Initials (example: FSP, R.B. or C, D.M.)

(To be completed by Pinebrook staff) L= Letter, T/C = telephone call, LM= left message, R/A = referral agent

| Date: | Your initials | L, T/C, Fax | to or with whom: | Detailed description of contact: |
|---|---|---|---|---|
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