

REFERRAL FORM
Selective Mutism Program

Referral Date: _____

Client Information

Child's last name: _____ Child's first name: _____

Child's date of birth: _____ Age: _____ Gender: Male Female Other

Child's ethnicity: _____ Child's primary language: _____

Referral Source Information

Referral Source:

Physician Therapist DHS Case Worker Self Other _____

Contact Person: _____ Agency: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

DHS Involvement:

Current DHS Involvement: Yes No – Skip to Caregiver Information

If yes, caseworker name: _____ Primary County: _____

Caseworker Phone: _____ Cell Phone: _____ Fax: _____

Caseworker Email: _____

Caregiver Information

Primary Caregiver 1: _____ Primary Caregiver 2: _____

Relationship to child: Biological Parent Legal Guardian Other _____

Preferred phone: _____ Secondary phone: _____

Address: _____

Insurance Information

Name of Primary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Relationship to Client: _____ Policy Holder Employer: _____

Reason for Referral

Has your child been diagnosed with Selective Mutism? No Yes

If yes, by who? _____ Phone: _____

In your own words, describe the child's needs and/or any specific behaviors of concern the child may be exhibiting.

Where does your child have difficulty speaking? (Mark all that apply)

Home School Public Places Other _____

With whom does your child have difficulty speaking with? (Mark all that apply)

Adults Peers Group Settings Other _____

Does your child have difficulty participating in age appropriate social activities (i.e., sports, birthday parties, play dates)?

No Yes

When did you first notice symptoms? _____

Please use the space below to elaborate on situations in which your child is impaired?

Additional Information

Any medical or behavioral diagnosis/concerns for this child? No Yes – If yes, explain

Any developmental concerns for this child (i.e., speech, motor, social skills, etc.)? No Yes – If yes, explain

Has child had a victimization experience? Yes* Suspected* No

*Complete below (check all that apply)

- Physical abuse Sexual abuse Neglect Psychological / Emotional
- Bullying Hate Crime School violence Kidnapping
- Community violence Accident War/terrorism
- Witnessing intimate partner violence (IPV) / Domestic violence (DV)
- Other: _____

When did event(s) occur? _____

Other Professionals

Therapist:	_____	Phone:	_____
Primary Care Provider:	_____	Phone:	_____
Psychiatrist:	_____	Phone:	_____
Speech Therapist:	_____	Phone:	_____
Other:	_____	Phone:	_____
Other:	_____	Phone:	_____

~ FAX completed forms to (405) 271-8835, ATTN: Emily Edwards ~

The parent/legal guardian will be contacted for additional information and, if appropriate, to schedule an assessment for the child.

→ A custodial caregiver must attend the intake assessment with the child. ←

Questions? Contact Emily Edwards at (405) 271-5700 ext. 30668.