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: Shawna Standiford ~

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 Shawna Standiford at (405) 271-5700 ext. 42679.