STRIVE
REFERRAL FORM

4701 Fairway Avenue
North Little Rock, AR 72116
Phone: (501) 771-8261
Fax: (501) 771-8263

Date of Referral: _____ Referral Source: _____ School Name: _____

School Phone Number: _____ Grade: _____ Primary Language:_____

Student's Name: _____ Date of Birth: _____ Age: _____ Gender: M or F

Social Security #: _____ Race: (W) (B/AA) (H/L) (NA/AI) (A/PI) Other: _____

Is the child in DHS/DCFS custody? Yes or No | Is the child in Foster Care? Yes or No | Former STRIVE Patient? Yes or No

---

Medicaid/AR Kids 1st #: _____ Eligibility (date): _____

Insurance Company: _____ Policy #: _____

Name Insurance is Under: _____ Group #:_____

Date of Birth of Insurer: _____ Insurer Social Security #: _____

Primary Care Physician's Name: _____Phone: _____
(Tier 1 - must obtain referral from PCP)

Reason for referral or concerns:

____ Short Attention Span	____ Poor Anger Control	____ Sadness	____ Anxiety (worries)
____ Impulsivity	____ Destructiveness	____ Isolation	____ Abuse - Sexual or Physical
____ Hyperactivity	____ Aggression	____ Self-Injurious Behavior	____ Behavior Issues

Please list any present or past mental health counseling, medication treatment, testing, previous diagnosis, court involvement:
_____
_____

Parent/Legal Guardian: _____ Relationship to Child: _____
First Middle Initial Last

Address: _____
Street City/State Zip Code

Parent Social Security #:_____ Parent DOB:_____

Cell Phone: _____ Email Address: _____

Employer: _____Business phone: _____

Emergency Contact Info: :_____ _____
Name Phone

Parent/Legal Guardian Signature: _____
(**Permission to Process Referral**)

Fax Completed Referral to 501-771-8263