

PATHWAYS
Luzerne Intermediate Unit 18
Referral Form

Provider 50 After School Program Partial Hospitalization STAP
Intake Information (Completed for all clients)

Date of Intake _____ Completed By _____

Client _____ DOB _____ Age _____

Parent(s)/Guardians _____ Phone Number _____

Home Address _____ County _____

Client MA # _____ SSN _____

Home District _____ Grade ___ Program _____

Referring Agent _____ Agency _____

Position _____ Phone Number _____

Insurance (select one) MA Private Other (Please Specify) _____

Is student receiving special education services (includes speech – only) "Y" "N"

If yes :

Initial Evaluation Date _____ IEP Date _____ Re-Eval Date _____

Level of Service _____ Type Of Support _____

Comments/Presenting Behaviors/Projected Services & Locations

Previous Mental Health Services

Please forward referral form to:

LIU 18 Behavioral Health Service
c/o Millie Fleming
368 Tioga Avenue
Kingston, Pa. 18704