



**WASATCH MENTAL HEALTH  
YOUTH DAY TREATMENT  
REGISTRATION / REFERRAL FORM**



Instructions: Please complete form and send or fax to Wasatch Mental Health, Youth Day Treatment Program, 1165 East 300 North, Provo, UT 84606 fax 801-375-4045. A representative will contact you regarding your application. Please call 801-812-5244 or visit [www.wasatch.org/ydt.html](http://www.wasatch.org/ydt.html) for questions regarding the programs. Please print, as illegible or incomplete forms will be returned.

CHILD INFORMATION					
Person completing form:		Relationship to child:		Current Medicaid Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Today's date:		Requested Program: <input type="checkbox"/> Stride Partial Day <input type="checkbox"/> Summer Program <input type="checkbox"/> Ascend Full Day <input type="checkbox"/> Ascend Partial Day (Kindergarten – 12 years old) (12 years old – 18 years old)			
Child's last name:		Child's first name:	In Utah State custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	DCFS Case worker:	Case Worker Phone:
Parent / Guardian:		Parent cell phone no.: ( ) ( )	Child Birth date: / /	Child Age:	Child Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Parent work phone no.: ( ) ( )		Parent home phone no.: ( ) ( )	
P.O. box:	City:	ZIP Code:	Child preferred name:		
School Attending:		Teacher:	Teacher Phone:	Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments:					
Note: Child must live in Provo, Utah or be in Utah State Custody to qualify for Ascend Full day. Youth in special education services are not eligible for the Ascend Full Day Program.					

The treatment team is an important part of the child's treatment. Youth Day Treatment should only discuss the child's case with those listed below unless directed by law. Team members can be added later. Please remember to include family members that may require contact with the Youth Day Treatment Program. Please indicate a team lead for the agencies by placing an asterisk next to a member below. The guardian / parent is by default a lead as they will be the first contacted. The team lead is responsible to disseminate information to the remaining team members regarding treatment.

TREATMENT TEAM (PLEASE INDICATE LEAD)				
Team Member:	Role:	Phone:	E-mail:	Signature (not required):
	Child			
*	Legal Guardian			
	Parent / Guardian / Foster			
	Physician			
	Therapist			
Stride and Ascend Staff	Day Treatment Providers	801-812-5244	wasatch.rbudge@state.ut.us	
	Case Manager			

Child:

**REQUIRED INFORMATION FROM PROVIDER**

Modalities added to treatment plan:    SDS 3-5 days    Case Management    Individual Therapy    Group Therapy

Goal added to treatment plan:    Improve role functioning at home, school and with peers    Improve family functioning

Skills Development Goals (add to treatment plan):

#1

#2

Required forms (up to date) that can be located in the child's chart:    SED    Treatment Plan    Acuity / Assessment Scale

**PRIMARY THERAPIST VERIFICATION**

Child Diagnosis:

Anticipated outcome of program:

I certify that a day treatment program is medically necessary for this child. This service will provide the least restrictive intervention for this child at this time.

\_\_\_\_\_  
*Primary Therapist Signature*

\_\_\_\_\_  
*Date*

**YOUTH DAY TREATMENT USE ONLY**

Staffing Date:

Outcome:

Anticipated Start Date:

Comments:

Stride Required:    Policy & Procedure    Release of information    Emergency Contact    Profiler    Welcome Letter Sent

Ascend Required:    Policy & Procedure    Release of information    Dress Code    Emergency Contact    Van / Bus rules  
 Caffeine Permission    Clinical Level Sheet    Medication Sheet    Group rules    Privileges    Profiler

Date:

Notes:

